

Understanding non-enrolment in Ghana's National Health Insurance Scheme: a view from beneath

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Master thesis in Development Geography

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University of Oslo, May 2014.

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Appreciation

My utmost thanks go to the Almighty God who granted me the ability and good health throughout this research process. I say Jehovah may your name be praised.

I should say that this work would not have been successful but for the dedication, advice and efforts of my affable supervisor Jan Hesselberg, Department of Sociology and Human Geography. Thanks, for your guidance I can now confidently carry out independent research with less difficulty.

Next, I wish to express my profound gratitude to the Norwegian Government and the Quota Scheme for awarding me a scholarship to study in Norway. I would not have been able to cope but for the funding I received. It is also my honour to thank the International Education Office for the advice it gave to ease my academic work.

Lastly, I am grateful to all the participants of this research work, especially to the staff of the Okwahuman South Health Insurance Scheme, the informants of my study sites, the Kwahu South District Assembly, and the workers of Kotoso Reproductive Health Centre. Special thanks to my partner for life Nana Oppong Amankwaa, course mates: Prince Michael Amegbo, Edem Asaase, Ibrahim Wahab and Daniel Oppong (gratis chairman), my family and friends.

God bless you immensely for your support, contributions, encouragement and motivation. May He restore unto you the strength you lost as we worked together.

Abstract

Ghana's National Health Insurance Scheme has not achieved full population coverage although it is a social health insurance scheme, a model increasingly gaining weight as carrying the potential to incorporate the poor and low income groups. Bearing similarity with numerous studies on non-enrolment, socio-economic factors are found to be the most influential explanatory reasons. However, additional significant non-economic variables are identified.

The study adopts the decision-making theories, and secondary literature on enrolment as the theoretical perspectives against which informants' opinions are explored. Individual interviews were conducted selectively, spreading across the desired socio-economic categories.

It is revealed that the ability to pay premium, employment and income level, dependency rate, risk perception, perceived health status, health-seeking behaviour, trust, quality of service, and continuous access to information are the pervasive decisive factors. Of significance are the play of politics, chieftaincy disputes, and geographical barriers. There are also challenges with indigent selection, scheme financing, service provision and coverage extension.

The study documents financial barrier as representing the greatest challenge. I recommend an improved indigent targeting method and incremental assistance to empower low income groups to enrol.

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Abbreviation

CBHI	Community Based/Mutual Health Insurance
DRGs	Diagnostic Related Groupings
FFS	Fee-for-Service
IRSNs	Informal risks sharing networks
NHIS	National Health Insurance Scheme
NHIF	National Health Insurance Fund
NHIA	National Health Insurance Authority
NDC	National Democratic Congress
NPP	New Patriotic Party
OSHS	Okwahuman South Health Insurance Scheme
SHI	Social Health Insurance
SSNIT	Social Security and National Insurance Trust
UHC	Universal Health Coverage
WHO	World Health Organisation

Chapter one

Introduction

In this thesis, non-enrolment in the Okwahu South Health Insurance Scheme: a district mutual and an affiliate of Ghana's National Health Insurance Scheme (NHIS) will be studied. Prior to the introduction of this scheme, health care use and accessibility for the majority of the Ghanaians was largely dependent on the ability to pay (Jehu-Appah 2011a). As health care was not accessible for a significant section of the population, reforms in this sector became necessary. Recognising health insurance as one of the approaches to achieving equity in health care, the country saw the need to introduce *health insurance*. The scheme is largely funded by tax contributions with individual premiums making up only 5% of the financing cost, a feature expected to speed up the drive for entire population coverage by eliminating the financial limitation to enrolment (Witter and Garshong 2009).

Notwithstanding this seemingly impressive financing mechanism, there is evidence of low enrolment, but there exist a dearth of knowledge in the explanatory reasons, especially regarding how the poor and low income groups who are the main target population for achieving equity in the health care system have benefited from the scheme. Only 36% of the population are covered after a decade of the scheme's introduction (Oxfam 2013) implying that universal health coverage (UHC) status has not yet been attained. Consistency and retention in the scheme has also been low, especially among informal sector workers (Agyapong and Adjei 2008).

Following a similar pathway used by the majority of the successful developed countries, the scheme was introduced with a focus on the formal sector to form the core of its membership, and to extend gradually to cover the entire Ghanaian population. Meanwhile, the country has a larger informal sector, many of who earn low incomes (Carrin 2002) suggesting that the well-known method might not be suitable in the Ghanaian context. Although the Insurance Act has a premium exemption policy for indigents, there are groups who do not fall into the indigent category but have limited ability to contribute and secure their membership in the scheme.

A study of the reasons for low enrolment is particularly important because the scheme is said to be non-profit in nature, an option seen as having the potential for attracting large membership. I have chosen the Okwahu South District as a study area because of its heterogeneous population

characteristics, a feature which in my view carries the potential to reveal varying and interesting findings.

Objective and research question

In this thesis, I will address the issues pertaining to non-enrolment in the study areas. Thus, I will explore the enrolment procedures, their influence on non-enrolment, the reasons explaining low enrolment and the challenges of coverage expansion. The research question is as follow:

❖ *What explains non-enrolment?*

In the pursuit to achieving the outlined objectives and to finding answers to the research question, I will use the qualitative method. The intention is to gather diverse opinions unrestricted to measurable variables, and perhaps identify further interesting issues not yet addressed in the existing literatures on non-enrolment.

Chapter outline

This thesis has five chapters and is structured as follows: it *begins* with an introduction of the purpose of the study and presents the objective and research question.

Chapter *two* throws more light on the concept of health insurance as it is an important keyword. An overview of the types of health insurance is given, bringing out the similarities and differences among them. The role of informal solidarity groups in mitigating health risk is discussed. An overview of some definitions of UHC and some underlying challenges for achieving it are highlighted. The chapter concludes with a discussion of Ghana's health care system, taking a look at the reforms and the events culminating to the introduction of the NHIS, as well as the participation and membership level of the scheme.

Chapter *three* explores enrolment into health insurance schemes. The discussion focuses on the general determinants of, and the factors which influence enrolment, and the theories which consist of the framework against which the thesis is examined. I show that some of the explanatory factors are interrelated although they may be discussed separately.

Chapter *four* outlines the methodological approach for the research. In this chapter, I discuss how I went about my data collection: the method and techniques I used, providing justification for the choice of these methods. I bring out the challenges and problems I encountered in the process, how I overcame them and what informed the choices I made in overcoming these challenges.

In the *last* chapter, the findings from the field are presented and analysed. This is done with reference to the framework provided in the early chapters of the thesis. I seek answers to the research question through an analysis of the information gathered from the field. The thesis concludes with a highlight of the findings and suggestions for improving enrolment.

Chapter two

The concept of health insurance

Dixon et al. (2011) define health insurance is an arrangement which presents people exposed to the uncertainties of future health shocks an opportunity to contribute to a fund from which they can draw when they are ill. To insure as used in this context means to protect one's self against the unexpected, unforeseeable and undesirable future health shocks that adversely affect human well-being. Health insurance offers financial protection to the insured by reducing out-of-pocket payments, and direct user fees or point of service payment for health care, thereby improving accessibility to health care (Chankova et al. 2008).

Health insurance can be financed through general taxes or through contributions by the insured and other stake holders. The latter is often referred to as a social health insurance (SHI) scheme. Financing through general taxes have proven to be more effective and easier to implement in countries which have large formal sectors and a strong tax base, owing to the ease with which revenue through taxes can be mobilised (Mathauer et al. 1996). In countries where the informal sector dominates, as typical of most countries in the south, revenue mobilisation through taxes could be difficult and limited, making SHI an easier option. Consequently, this has evolved as a preferred intervention which various countries are using to extend health insurance to the majority of the people in the informal sectors in the south.

Based on the ownership, the kind of benefit provided, degree of risk pooling and the management of a health insurance scheme, it could be classified as private non-profit, commercial, a mutual or community based. For a proper understanding of this thesis, it is essential to explain the different types as they fall within the framework of health insurance. I will highlight the individual features, commonalities as well as the distinctions among them, their potentials and pitfalls as models for achieving UHC. All the types are operational in Ghana.

Commercial/Private health insurance

This type of health insurance is profit-oriented or motivated by profit-making motives. In setting premiums, consideration of the expected health cost of potential clients is an overriding principle. Motivated by the expected gains, the service provider fixes premium based on the

assessment of individual risk levels. "Those who have high risk levels pay more whereas those who have low risk pay less" (Criel and Waelkens 2003: 783). Subscription is not compulsory and membership is a factor of the ability of the client to pay. Cross-subsidization and solidarity are not important tenets of commercial schemes as they do not play roles in increasing subscription and utilisation. Commercial schemes have been criticised of cream-skimming (McIntyre et al. 2008): a practice of policy design which makes the schemes attractive to below average risk groups, while excluding high risk groups so as to maximise profits. This makes commercial schemes less efficient models for achieving UHC.

Community Based/Mutual health insurance (CBHI)

CBHI is used to refer to various health insurance schemes distinguished based on the design adopted by a group of people within a given setting. Irrespective of the distinguishing features, the following are shared characteristics among these schemes: an element of social dynamism—they are organised, owned and managed by a group who share common characteristics such as those identified by geographical location, ethnicity, religion, occupation or gender, usually those outside formal employment. Decision-making processes do not divorce ownership from participation, participation is not compulsory, and solidarity is a feature as it has an embodiment of risk-sharing. Premiums are not fixed based on calculated risk for individuals (Criel and Waelkens 2003).

The features outlined above may however be applied to a lesser or a greater extent. For instance, the scheme owned by an employee association may insist on compulsory participation by its members. Similarly, one owned by a health service provider may not have an embodiment of extensively developed avenue for participatory decision-making and management. As Criel et al. (2008) point out, most CBHI schemes in West Africa have been set up based on social and political dynamism, in which case participation and management by the community is the most important feature.

A classification of mutual schemes has been made based on ownership, membership, management and risk coverage. Ownership as pointed out already is defined on the basis of who takes the initiative in the scheme's establishment, rather than on legal basis. It can be classified as community-based where a group of people within a community come together to initiate it, or provider-driven when it is initiated by a group of service providers, a non-governmental

organisation or a trade union within the community. Provider-driven schemes can further be classified on the basis of the character of the provider. For instance, it could be a faith-based, a government institution or a private provider (Criel et al. 2008).

Management of CBHI schemes is a factor of control and organisation. They can be managed by elected representatives who are also members, service providers or can be contracted professionals with the managerial know-how. Membership may be distinguished based on geography, ethnicity, gender, religion or occupation. Membership may comprise of the people of a particular village or town, ethnic group, an organisation or those using a common health facility. The scheme may be designed to cover high risk or low risk ailments. High risk events are those that lead to hospital admissions, whereas low risk schemes are those which cover common and low cost events such as first-line hospital consultations (Criel et al. 2008).

Mutual schemes play an important role of offering financial protection against health risk as well as enhancing accessibility to health, particularly where prepayment and risk-sharing schemes do not exist. However, "they have a limited ability for scaling up to achieve UHC due to their small risk-pools, voluntary character and regressive premium rates which in practice make the poor pay more" (Oxfam 2013: 9).

Social Health Insurance (SHI)

SHI originated from the European countries, first in Germany by chancellor Otto Von Bismarck as a model for compulsory and nationwide health insurance coverage in 1884. This was the Bismarck model (Criel et al. 2008). A major source of funds for financing for this model was state subsidies to provide health care to the unemployed, poor and low income groups. Other non-European countries achieved universal coverage using a new model (tax-financed Beveridge model). The distinguishing feature of the two models is that one is mainly financed via state support, whereas the other is financed mainly with revenue from general taxes. The later financing mechanism is increasingly becoming common due to escalating health cost. Each of the models though has proven to be efficient in achieving universal coverage; the success is dependent on some factors: government stewardship, political stability, civic voice and administrative competence (Criel et al. 2008).

SHI operates on a principle of resource pooling in the form of financial contributions, risk-sharing, risk equalisation, cross-subsidisation and solidarity (Carrin 2002). A common fund from which funds are drawn to cover the health cost of the insured is usually created from contributions from members. These could be mobilised from formal sector employees, employers, the self-employed, central governments, and from external sources such as donors and other stakeholders. The definition by Criel et al. (2008) affirms the equity and solidarity principles, adding further a right-based perspective.

"Social health insurance pursues nationwide risk-sharing from a public-right based perspective and in a non-profit environment. Premiums are generally proportional to income, independent of the individual risk, and paid principally by employees and their employers through legislation and financial levies. Social health insurance implies both cross-subsidies from the healthy to those with poor health, and from the rich to the poor, provided that affiliation is mandatory and universal." (Criel et al. 2008: 783)

The risk sharing and risk equalisation principles imply that both high and low risk individuals who insure are exposed to the same benefit of acquiring access to health care at same cost. Some other peculiar characteristics identified by Jutting (2004) are that a SHI scheme is non-profit based, enrolment is voluntary in practice, benefits are specified, and contributions from the informal sector take the form of premium payments.

SHI schemes have been promoted by donor organisations such as the World Bank and the International Monetary Fund as an efficient model for scaling up insurance coverage as they have proven successful in some developed countries. However, attempts to duplicate and transfer this model in the developing countries have not achieved similar successes (Oxfam 2013). Conditions which have underpinned the successes have differed from that which existed in the developing countries. In the developed countries, these schemes often started with the larger salaried workers in the formal sector and scaled up gradually to cover those outside of formal employment. Payroll deductions were easier and more efficient administration systems were instituted to mobilise revenue from taxes.

On the contrary, most developing countries are characterised by larger informal sector workers, many of whom have limited abilities to pay premiums due to income inequalities (Carrin 2002). Moreover, the mandatory participation principle is theoretical but in practice it is difficult to enforce. Besides, low revenue from formal employees, tax evasion, corruption in the revenue authority service, difficulties in determining incomes of the informal workers owing to the lack

of records on incomes, are but few of the challenges to successfully scaling up SHI to achieve UHC in the developing countries (Oxfam 2013).

Shared characteristics of the health insurance models

All three types of schemes identified above share the principle of risk-sharing by pooling resources together via financial contributions. The funds created are used for financing the schemes. The differing characteristics for each of the three types originate from the rationale behind them which affect the scope of coverage.

Informal risk-sharing networks (IRSNs) and insurance

Having identified the models of health insurance and their characteristics, it is important to discuss the existence of traditional risk-sharing networks and their role in promoting accessibility of health care in Ghana. De Bock and Gelade (2012) assert that before the introduction of health insurance schemes, traditional IRSNs played a significant role in offering financial protection against risk and vulnerabilities such as crop loss and catastrophic health care expenditure among low income groups in Ghana, especially in the absence of CBHI schemes.

The source of finance for such a support included individual and households' incomes, savings, and the sale of economic assets (Asenso-Okyere et al. 1997). Within communities and villages, regular group contributions known as *susu* served similar purposes as insurance for members as they could loan money from the pool of financial resources that the group had accrued. Others with the limited ability to save relied on borrowing, and the use of traditional healing practices as ways of maintaining good health. Extended family members often supported their sick relatives in bearing the cost of seeking health care. While *susu* promoted accessibility to health care, it was limited and lacked the ability to reach the larger proportion of the population, especially those who could not contribute. The family support network has also been weakened due to worsening economic conditions, urbanization and the influence of western cultures which promote the nuclear family system (Aboderin 2004).

Universal health coverage (UHC)

Several meanings have been given to UHC and it is important to highlight some of them as the term is often misrepresented. For the World Health Organisation (WHO), UHC is achieved when all people have access to quality and comprehensive health services at affordable cost, and without financial hardship through protection against catastrophic health expenditure (Oxfam 2013). The services referred to encompass preventive, curative, promotion, rehabilitation and palliative care. In order to achieve UHC, the WHO advocates that progress should be made on three fronts. These are: the range of services that are provided, the percentage of the population covered, and the cost of the services provided that are covered. This implies that this pursuit takes the perspective of increasing population coverage, reducing the cost of health care, and improving and increasing health care services provision.

Similar views have been shared by Knaul et al. (2012). First, the phrase encompasses universal enrolment which legally entitles all to health benefits which are publicly funded by organised insurance. Second, it implies access to holistic health care unimpeded by financial inadequacy and third, it guarantees to all an equal and the maximum attainable health care from a high quality and a standardized package of health services.

To MacIntyre et al. (2008) the core principles that should be considered are universality, equity and solidarity. This in effect means that the ability to pay for health care should not be an overriding factor for accessing quality health care. Oxfam (2013) argues that UHC is about the rights of individuals to health care irrespective of their ability to pay. To this effect, it makes explicit that governments should take on the initiative in ensuring that funds for health care are equitably raised through pooling arrangements and resources are actively redistributed to those with the highest health needs. It advocates a shift from health care entitlement based on employment or contributions to one based on citizenship and, or residency.

Operational difficulties challenging the efforts at achieving UHC

The efforts to cover an entire population with any of the models discussed may be hindered by some operational difficulties. A review of literature (Carrin 2003, Jutting 2004, Waelkens et al. 2004, Baltussen et al. 2006, Schneider and Hanson 2006, Ndiaye et al. 2007, McIntyre et al. 2008) reveal the following as some notable challenges which limit the development and scaling up of health insurance schemes: lack of a clear legislative and regulatory framework, insufficient

risk management measures, low enrolment rates, weak managerial capacity and high overhead cost.

Weak managerial capacity as a result of inadequate skilled personnel affects scheme expansion. The problem may stem from lack of funds to organize periodic training programs for upgrading managerial staff skills, or the absence of educational institutions tailored to meet the skill needs of the health insurance sector. Management plays roles in fixing fair premium rates, publicizing and marketing schemes, administering, financial management and designing effective tools for risk management. Shortfalls of management pertaining to any of these roles may affect the success of a scheme as they limit its ability to grow.

Some schemes emerge in an ad hoc manner, especially where governments lack policies to regulate their establishment and activities, or that they exist but are weakly enforced by governments. While community members and solidarity organisations can initiate the establishment of insurance schemes, the national governments have the responsibility to provide a regulatory framework for their growth. A negligence of such a role results in schemes operating in a counterproductive manner as they are forced to operate in uncertainty (De Allegri et al. 2006b). Few countries have developed regulatory frameworks for the establishment of schemes, but enforcing the components is also another challenge. For instance, De Allegri et al. (2006b) identified Ghana as one of the few countries in the sub-Saharan region which has a regulatory framework for health insurance schemes. However, policies to subsidize the establishment of large scale schemes to increase coverage have been rather difficult to implement.

In addition, high overhead cost presents another challenge. Unless support is received from donor agencies and international financial organisations, raising the initial financial resources for the establishment of health insurance schemes is often difficult. Usually, extending coverage requires that operational cost is minimised and revenues maximised in order not to compromise on the quality of health services provided even as utilisation increases. The problem of ensuring financial sustenance might be peculiar with SHI schemes than with commercial and private ones as they are not for profit. Schemes which are provider-based might be easier to operate due to the possibility of integrating the insurance functions, management and service provision. However, they may also be faced with the difficulty of estimating real cost of operations, often leading to underestimation (De Allegri et al. 2006a).

Another challenge faced by health insurance schemes is their inability to achieve maximum population participation. Low level of enrolment, between 1% and 10 has been recorded by a number of CBHI schemes in sub-Saharan Africa (De Allegri et al. 2006a). While most schemes suffer from inadequate enrolment, others which sustain a considerable level of participation face problems of fluctuation in retention.

Ghana's NHIS is reported to have witnessed an increase in enrolment in the early years of its introduction; however, low level of retention has also been identified as a hindrance to increasing coverage (Atim and Sock 2000). Higher coverage has been found among the wealthiest or least poor, schemes which are not managed directly by community members, those which receive adequate support or subsidies from the government, and make participation compulsory, such as schemes established by cooperatives and microfinance organisations which insist that all their beneficiaries enrol, as well as schemes that emerge from institutions which already exist such as one for formal employees (Criel et al. 2008).

Schemes which are unable to secure adequate level of participation may be those with small risk pools and require voluntary membership. It should be noted that where health insurance schemes are unable to cover the poor, they fall short of their potentials for addressing health inequalities, enhancing utilisation, and providing financial protection against the cost of ill health.

The inability of health insurance schemes to incorporate efficient risk control measures in their design may also challenge the success of their implementation. Inadequate risk management measures encourage fraudulent consumer behaviours such as moral hazard or over-utilization of health services, adverse selection: the practice whereby the risk pool consists of a greater number of those who have the highest health risk, and less of those with the least health risk), and service provider fraud. The most common mechanisms used by schemes to control adverse selection and service over-utilisation are waiting periods, referral systems, co-payments, deductibles and social control measures.

While deductibles have been widely introduced in most schemes, the incorporation of co-payments has been rather slow. It has been identified that this mechanism is suitable for small schemes which are hospital-based and do not operate referral systems, a feature which is lacking in most schemes in sub-Saharan Africa (De Allegri 2007). Additionally, studies show that the use of social control as a means for mitigating consumer fraud in sub-Saharan Africa has failed to achieve the desired results, although some schemes still rely on them (Atim and Sock 2000, Baltussen et al. 2006).

Since provider fraud equally raises the cost of operating a health insurance scheme, a number of schemes are challenged with designing effective measures for detecting and controlling such behaviour. Commonly used reimbursement systems for service providers are the Fee-for-Service (FFS) and the Diagnostic Related Groupings (DRGs). These systems, particularly the FFS have proven to be less effective, yet a significant number of schemes continue to rely on them (Atim and Sock 1998, Bennett et al. 1998, Baltussen et al. 2006). Although capitation payment has been identified as having the potential to reduce provider fraud more efficiently, few providers are willing to accept this form of payment as they will be compelled to bear part of the risk involved (Carrin et al. 2005, De Allegri 2007).

Ghana's health financing context: The NHIS

Since independence in 1957, Ghana's health financing has undergone a series of considerable reforms. Immediately after independence, the Nkrumah government introduced free health care delivery for all Ghanaians, thereby improving health care accessibility, utilisation and equity. However, events took a downward turn during the structural adjustment period of the 1980s. Under the Rawlings' administration, a FFS system popularly known as *cash and carry* was introduced into the country's health care system in 1985. The rationale behind this reform was to reduce government's cost of financing health care and improve health care delivery.

On the contrary, the reform rather had a negative effect on health care access and use (Jehu-Appiah et al. 2011b) as the majority of the poor could not afford the cost of health care. Asenso-Okyere (1999) asserts that it did not only widen inequalities in accessibility and utilisation, but also produced detrimental effects on the health-seeking behaviour of the poor. The majority of those who could not afford the cost of formal health services resorted to practices such as delaying treatment, self-medication, and the use of traditional medicine, spiritual healing and no treatment. Calls were made by the populace and concerned organisations to redress the negativities of this reform, and improve the health care financing by eliminating the *cash and carry* system and to improve equity, accessibility and the utilisation of health services.

The NHIS was a response of the New Patriotic Party (NPP) to the calls for improvement in Ghana's health financing. The scheme was introduced in 2003 based on the Insurance Act 650. This Act mandated the establishment of District-Wide Mutual Health Insurance Schemes and to

charge an annual premium (Jehu-Appiah 2011a). To this effect, more than a hundred and fifty schemes have been established across the ten regions of Ghana.

The sources of funds for the scheme include the following: a 2.5% levy which is a value-added tax on most goods and services, excluding majority of foodstuffs and common consumables by the poor. This levy goes into the National Health Insurance Fund (NHIF) which is managed by the National Health Insurance Authority (NHIA). The revenues accrued to the Fund are used to insure exempt groups and to support financing the district schemes. Social Security and National Insurance Trust (SSNIT) contributors, the majority of who are employed in formal jobs pay 2.5% as deductions on their monthly contributions to the NHIS. They then secure their membership by paying a registration fee and obtaining their membership cards. Those in informal employment do not contribute to SSNIT and so are required to make premium and registration fee payments annually. Other sources of funds for the scheme are external donations and government miscellaneous (NHIA 2011).

The scheme has an exemption policy for indigents. Per the Insurance Act, indigents are those with no source of income; do not receive support from others with an identifiable source of income, and those with no identifiable residence. The Insurance Act legally establishes mandatory participation. However, in reality it is challenged by non-compliance and has been difficult to enforce. Even though premiums per the scheme's policy are supposed to be based on income levels as a mechanism for achieving equity, it has also been a challenge as there is no reliable data source for determining the incomes of informal sector workers (Jehu-Appiah 2011b).

The scheme makes available a benefit package which caters for about 95% of the disease burden of Ghanaians (Witter and Garshong 2009). This includes pre-natal and post-natal care, outpatient consultations, inpatient care, emergency, dental, eye care and shared accommodation. Subscribers do not pay deductibles, and there are no co-payments. An inbuilt mechanism of the scheme for checking adverse selection and moral hazards include a three month waiting period and a referral system. Members who fail to renew their membership within three months of expiration are allowed to serve this penalty of waiting during which they cannot access health care with their membership cards.

Health service providers are contracted for the NHIS members by the district schemes. These are accredited service providers of the Ghana Health Service. They could be private, public or

church-based health service providers. After submission of claims to the district schemes, the service providers are reimbursed based on the Ghana DRGs.

Participation and active membership of the NHIS

Reports revealed that the scheme as at 2011 was operational in 145 out of the 170 districts in Ghana (NHIA 2011). Regarding enrolment and the percentage of the population covered, reports given have been quite contrasting. The NHIA reports suggest that in 2011, 65% of the Ghanaian population were registered but 48% were enrolled. Contrary to this, the Innovations for Poverty Action reports enrolment to be below 18%. To extend coverage, the scheme is employing the use of mainly exemption policy, sensitisation programs and the organisation of periodic mass registration exercises. The scheme's report shows a distribution of its active membership by category as follows: SSNIT contributors 4.5%, SSNIT pensioners 0.3%, informal sector 36.4%, indigents 4.2%, elderly (70 years and above 4.9%) and under 18 years 49.7%. A review of the distribution reveals that the groups which qualify for premium exemptions consist of more than 50% of the active membership of the scheme.

Chapter summary

In this chapter, an overview about the concept of health insurance has been given. The types of health insurance have also been identified and their distinguishing and common features have been explained. I have argued that each of the models has inherent merits as well as pertinent drawbacks, and that the success of each for achieving UHC is influenced by the existing socio-economic and political situations, thus it is context-dependent. A particular model or a combination of the identified may help to cover an entire population. It is therefore imperative that the purpose for introduction and a thorough examination of the existing conditions in an environment is done before any of the models is opted for. I have given an overview of the traditional risk-sharing networks which existed in Ghana prior to the advent of health insurance, and outlined some meanings of UHC, and the challenges to coverage extension. The chapter concluded with an overview of Ghana's health care sector reforms, how its insurance scheme came into existence and the level of participation and membership.

Chapter three

Enrolment into health insurance schemes: a conceptual overview

Introduction

Although health insurance schemes play important roles in offering financial protection against the cost of illness and ensuring better access to health care, they often fall short of their objective. Low enrolment limits the advantages that can be obtained from participation, more importantly among the poor and low income earners who should benefit most. The problem is even more pronounced in the sub-Saharan region of Africa as De Allegri et al. (2006b: 852) point out:

"the problem of low participation in health insurance assumes acute proportions in sub-Saharan Africa, where schemes rarely attain 10% coverage among target populations. For this reason, they often cease to exist within a few years of their inception".

A number of studies (Criel and Waelkens 2003, Basaza et al. 2008, Mathauer et al. 2008, Dong et al. 2009, Osei-Akoto and Adamba 2009, Jehu-Appiah et al. 2011b) have identified various socio-economic factors: age, income, gender, education, health status, religion, ethnicity, scheme characteristics, household characteristics, community perceptions, trust levels, distance from a health facility, and benefit package, the level of co-payments, the presence of informal risk management groups and solidarity levels, among others as explanatory factors. While all the reasons are significant, not all might be true in a given geographic context. This should be expected because different geographical areas, societies and economies present individuals with different opportunities and limitations. Below, I review some determining factors of enrolment into health insurance schemes, and some notable reasons for non-enrolment.

Determining factors of health insurance uptake

Gender determines enrolment. The gender perspective can be analysed from these points of view: Different genders have different health needs. De Bock and Gelade (2012) argue that females are more likely to demand health insurance compared to males because females have special health risk which relate to child-bearing and pregnancy. They are also more vulnerable to

sexually transmitted diseases like HIV/AIDs, and are at higher risk to domestic violence. De Allegri et al. (2006a) confirm this in a study which found higher enrolment rates among female headed households.

Age also influences the health needs of individuals. LeMay-Boucher (2007) makes explicit that the elderly, young and women in their reproductive ages have higher demands for health care. As a result, enrolment rates are higher among them compared to other age groups. Similarly, the author found that households which have a large number of dependents are more likely to enrol into insurance than those with few dependents. A higher number of dependents suggest a greater possibility of adverse health effects which translates into a higher demand for health insurance.

Income has been identified to have a strong relationship with enrolment. All things being equal, higher incomes improve the ability to pay premiums, thereby increasing enrolment. Jehu-Appiah (2011a) has shown that income plays an important role as a determinant of enrolment. Income is closely related to employment and so the employed may have a higher probability to enrol than the unemployed. As income increases and unemployment decreases, people are more willing to take up health insurance (Asenso-Okyere et al. 1997).

A contradicting situation could however occur when an increase in income or wealth correlates with a decrease in risk aversion. This will rather enhance the ability of the individual to handle unexpected financial burdens relating to health care, thereby reducing the willingness of the wealthy to take health insurance. The poor and low income groups may be more likely to take health insurance because they are more risk-averse than the higher income groups (Monheit and Vistnes 2006). These groups tend to have a higher aversion for risk and may sacrifice satisfying consumption for purchasing health insurance in order to protect their limited assets against catastrophic health expenditure as it can push them further below the point of survival. De Bock and Gelade (2012) assert that the enrolment among low income groups can also be high where effective premium subsidies reach them, or where they easily have access to credit facilities. In essence, this implies that credit constraints can limit the ability of the poor to purchase health insurance.

Generally, education links positively with enrolment. Education plays a role of increasing the understanding of the health insurance scheme rationale and the benefits of membership, as well as enhancing awareness of the existence of insurance schemes, various available options and membership procedures (Monheit and Vistnes 2006). Closely related to education, Edgman-

Levitan and Cleary (1997) identify the access to relevant information and knowledge about health insurance as an important factor which positively affects enrolment.

Additionally, the individual's self assessment of health affects the decision to use health insurance. Jowett (2003) asserts that a person who assesses himself as healthy might be less willing to take health insurance than one who is less healthy. In the same way, families which have members with higher health needs such as the elderly, disabled, pregnant women and children may be more willing to insure so as to cut down on health care expenditure and maximise benefits from an insurance membership. In other words higher expected utility from health insurance increases enrolment.

Solidarity is a principle of health insurance, and the degree of cohesion and the level of solidarity in a given society may also have an influence on enrolment rates. When solidarity is high in a community, it means that the individual members are willing to support one another to manage risk. This principle means that not all the contributors will have the same level of benefit within a given period of time. A member may not seek health care before the validity period for his membership expires, but he will have to contribute again to sustain his membership. The acceptance of such a principle by community members is necessary to enhance enrolment since health insurance does not operate on reciprocity. Solidarity groups may build up a sense of cohesion which can serve as a solid ground for the introduction of formal insurance schemes.

On the contrary, Schneider (2004) argues that solidarity and support received through membership in IRSNs such as savings groups, family members and friends may lower individual's desire for insurance by decreasing the uncertainty of financial difficulties in the event of illness. They may also crowd out formal health insurance schemes, thereby negatively affecting enrolment. Besides, solidarity groups usually operate on a principle of reciprocity which contradicts that of formal health insurance schemes. In this case, higher solidarity adversely affects enrolment. In line with Schneider, LeMay-Boucher (2007) found out in Benin that the presence of solidarity groups hindered enrolment into formal insurance schemes. The author again identified that these groups are usually within the reach of members who find them more convenient and trustworthy compared to formal insurance since they are often managed and owned by members.

Jehu-Appiah et al. (2011b) has identified that perceptions of people about health insurance scheme, service providers and disease causation have an effect on enrolment. Negative

perceptions reduce enrolment. Perceptions about health insurance schemes may be related to the rates of premium, convenience of membership and benefit package. Perceived low premiums increase affordability and this has the effect of increasing enrolment. However, where there are high co-payments and inflexible registration processes, enrolment may be low though premiums are perceived to be low. Likewise, enrolment might be low at low premiums when health services provided to the insured are perceived to be of poorer quality than that offered to those who pay user fees at point of service.

An extensive benefit package has the ability to attract people to enrol because members may not have to bare additional health cost outside their membership contributions, or they may pay very little even if there are co-payments. An extensive benefit package is one which covers a wide range of health risks or diseases, thereby maximising the value and benefits that members can derive. Co-payments reduce the value of a benefit package, whereas the absence of co-payments maintains its exact value which motivates enrolment. Not only does a comprehensive benefit package increase enrolment but also the extent to which the package corresponds to, as well as meets the needs of the intended population (De Bock and Gelade 2012).

Convenience may relate to the length of waiting periods for insurance membership cards, enrolment procedures and modalities for premium payment. With regards to health care provision, factors such as the availability of high quality of health care, low transition cost in seeking health care (in terms of distance and transportation cost), and positive provider attitudes towards the insured are positively associated with enrolment.

The trust in insurance schemes pertains to the assurance that members can actually rely on such schemes for financial support when they experience health shocks. The inability of an insurance scheme to payout when members are in need is likely to erode trust, thereby limiting enrolment (De Bock and Gelade 2012). In communities where members have had previous bad experiences with financial organisations such as microcredit schemes, it might be difficult for a newly introduced health insurance scheme to win the trust of community members to enrol.

Furthermore, community and cultural beliefs about diseases causation can have an effect on enrolment. People who associate disease causation with spirituality are less likely to take part in health insurance (De Allegri et al. 2006b). It should be emphasised that the ideas people hold about disease causation can be closely linked to their health-seeking behaviour. One with a belief that ailments are caused by witchcraft or unknown spirits may not see the need for health

insurance and is likely to seek health care outside formal health care. Such a person may prefer alternative methods like consulting a spiritual healer or a traditional herbal practitioner.

Moreover, religiosity has been found to be significant in enrolment. Religious beliefs can affect people's risk perception. Osei-Akoto and Adamba (2009) assert that a strong belief and reliance on God and prayers for preventive health can reduce demand for health insurance, likewise the belief that buying health insurance implies inviting sickness (Baidoo and Buss 2012). From this analysis, one can argue that communities which are highly religious might have low enrolment rates. However, the opposite situation may also be true where religious and faith-based organisations like churches take the initiatives in making formal health care accessible through the establishment and management of insurance schemes and health care centres, as well as in the provision of subsidies to community members and members of their organisations.

Ethnic diversity is another factor which affects enrolment but has not been extensively discussed in various literatures on health insurance enrolment. Ethnic diversity and heterogeneity within communities may reduce trust, solidarity, willingness to support others, and cohesion which is necessary in ensuring the success of health insurance in particular and welfare programs in general (Putnam in Osei-Akoto and Adamba 2009). This argument presupposes that countries and communities which have higher levels of homogeneity can easily implement health insurance and extend coverage than more heterogeneous societies. Osei-Akoto and Adamba (2009) argue that most developing countries are highly heterogeneous, a probable reason for the lower levels of health insurance coverage, as well as the difficulties in achieving universal coverage.

Reasons for low level of enrolment in different contextual settings

A major challenge most countries are facing in their efforts to increase health insurance coverage is how to include the poor and those in the informal sector (Carrin 2002). Various developing countries including Ethiopia, Ghana, Kenya, Rwanda, and Senegal which have implemented SHI have large informal sectors characterised by low, non-regular and non-taxed incomes (Mathauer et al. 2008). Consequently, such countries experience difficulties in mobilising sufficient revenue from taxes to subsidise premiums, provide premium exemption for the poor, and increase enrolment.

In some countries, there are policies to incorporate the poor but they are either not well implemented, or insufficient. Ghana's NHIS though has a policy to cover the poor; in practice has fallen short of its objective. Jehu-Appiah et al. (2011b) identifies that targeting of the poor is inefficient as income levels of the self-employed in the informal sectors are difficult to determine. There are also groups who qualify as indigents but are unaware of the procedures for obtaining benefits. Owing to this, enrolment remains low among low income groups.

Kamuzora and Gilson (2006) have identified the lack of a coherent and a well defined legislative framework for health insurance as one of the reasons for low enrolment. For any scheme to function well there is the need for effective coordination and coherence among the management and implementing bodies such as the central government (in the case of a national scheme), scheme managers at decentralised levels, and fund management bodies. In Tanzania, the lack of effective collaboration between district managers and the Ward Development Committees in the implementation of the Community Health Fund was found to have an effect on coverage extension to the poor and the low income groups. The district managers insist on complying strictly by the Community Health Fund Act of 2001, thereby rejecting request from the Ward Development Committees to exempt some groups from premium payment (Kamuzora and Gilson 2006).

Inability to pay premiums has been identified as one of the major limitations to enrolment, especially in those contexts where well targeted subsidies for low income and poor groups are non-existent (De Bock and Gelade 2012). In the Nouna District in Burkina Faso, De Allegri et al. (2006a) found that the lack of financial means and the inability to afford premiums poses a great barrier to enrolment. Community members reported that paying the set premium to cover a household is preferred to paying to cover an individual.

Wang et al. (2005) identify that in rural China the inability of farmers to pay premiums is a major limitation to enrolment. Similarly, Criel and Waelkens (2003) reveal that the declining subscriptions to the Maliando Mutual Health Insurance Scheme in Guinea-Conakry are as a result of the inability to pay premiums. Further, In Ethiopia, Asfaw and Braun (2004) found that enrolment in community health insurance remains low due to the inability to pay premiums. Basaza et al. (2008) also confirm the role of the inability to afford premium as significant in Uganda. Sulzbach et al. (2005) find a relationship between the inability to afford premiums and low enrolment in the Nkoranza and Kwahu Districts in Ghana. In Kenya, high premiums and inflexible premium collection schedules limit enrolment (Mathauer et al. 2008).

In some contexts, the modalities of payment may present a major challenge. In the Nouna District of Burkina Faso, De Allegri et al. (2006b) identified that the uninsured preferred instalment payment of premiums to annual or monthly payments. In his study, community members preferred that the payment periods were tuned or adjusted to meet their cash seasons, particularly harvest periods for the rural farmers.

In Rwanda, a study reveals that the uninsured do not like the timing for premium payment. The premium payment period is fixed at the start of a civil year when they have to also pay school fees. This makes it difficult for them to enrol (Morestin and Ridde 2009). Similarly, Jehu-Appiah et al. (2011a) identify that some uninsured groups in some parts of Ghana find the timing of premium to be inconvenient. This implies that premium payment per se might not always be a major problem, but rather pertinent features of an insurance scheme design such as the timing and modalities of payment.

A health insurance benefit package which does not cover a significant percentage of the disease burden of the insured or requires high co-payments and deductibles discourage enrolment. In the Jos City in Nigeria, enrolment in the NHIS remains low because the scheme exempts quite a number of diseases from the benefit packages (Onyedibe et al. 2012). In the study context, the majority who were uninsured did not find a significant difference between the cost of health care incurred by the insured and that of the uninsured, hence the low level of participation.

The benefit package of the Ishaka Insurance Scheme in Uganda does not cover chronic diseases and this explains the high dropout rates which have been recorded (Basaza et al. 2008). In the Thiés Region in Senegal, the mutual schemes recorded low participation because they required the insured to bear the cost of health care and submit claims for reimbursement later. Similarly, in Rwanda, the insured paid 10% of the cost of health care. These features of the insurance schemes have been identified as reasons for the low participation of the poor as they found co-payment unaffordable (Morestin and Ridde 2012).

Inefficiencies and operational difficulties in the NHIS's administration have also been identified to contribute to low enrolment in Ghana (Jehu-Appiah et al. 2011a). These related to membership registration, insurance cards production and distribution. Members had to wait for a period (between three to six months) before they received their membership cards. The delays discouraged enrolment, though the idea was to prevent adverse selection.

Institutional rigidities also accounted for low enrolment in the Jos City in Nigeria (Onyedibe et al. 2012). In some parts of rural China, some community insurance schemes signed up members only once in a year and on a particular day. Those who decided to join later were not admitted. This rigidity was found to keep a significant number of potential members outside the scheme (Carrin 2002).

Moreover, poor quality of health care delivery to the insured may explain low enrolment. This may relate to long waiting periods for health care, excessive prescription, poor referral systems and differential treatment based on the socio-economic and insurance membership status. Preferential treatment given to the uninsured as against that received by the insured is a disincentive to enrolment. A case on point is identified by De Allegri et al. (2006a) and Dalinjong and Laar (2012) in the Nouna District in Burkina Faso and the Builsa and Bolgatanga Districts in Ghana respectively where some insured experienced long waiting hours for health care, verbal abuse and discrimination in favour of those who make upfront payment. The insured expressed dissatisfaction with the attitude of health workers. Again, some scheme members reported that they were not well examined by doctors as they saw them as not making direct contributions to the health cost financing of the providers.

Owing to the delays in the reimbursement of some service providers in Ghana, there is usually lack of funds for the procurement of drugs for the insured. Some providers therefore prescribe drugs for the insured to buy, thereby reducing the benefits they derive from health insurance (Jehu-Appiah et al. 2011a). It should be emphasised that people who have had such experiences with health insurance are likely to redraw their membership or influence others who are not enrolled to stay out of such schemes.

Scepticism about an insurance scheme reduces trust and this has a negative effect on enrolment. As De Allegri et al. (2006a) found in the Nouna District in Burkina Faso, scepticism about health insurance may relate to the lack of adequate knowledge, past unpleasant experiences and resistance on the part of health care providers to the initiative of health insurance. In the above mentioned study context, some of the uninsured had an unpleasant experience with schemes which took their contributions but later disappeared without offering them any benefits.

Similarly, enrolment into The Safe for Health Uganda and the Ishaka community schemes in Uganda have been low due to inadequate trust. Some community members had not enrolled because they were once cheated by some financial organisations that collected their

contributions but made away with them without fulfilling their promises. Community members were therefore sceptical about the credibility of these schemes (Basaza et al. 2008). In Kenya, public services and parastatals are faced with corruption problems. As such, the NHIS of Kenya in general and fund managers in particular suffer from this negative perception which affects trust and limits enrolment (Mathauer et al. 2008).

Long distance from a health facility or a health service provider translates into a high cost of seeking health care which will be borne by the insured. Among the insured in the Self-Employed Women Association health insurance scheme in Uganda, members complained that the cost of transportation to a health facility discouraged them from utilising health services, even though they had insurance (Morestin and Ridde 2009). Similarly, in the Asante-Akim District in Ghana, there exist a negative association between long distance from a health care facility and insurance coverage. Enrolment is low among populations living further from a health facility (Sarpong et al. 2010). This makes the insurance scheme unattractive to a significant number of potential members, especially in the rural areas where there is unequal access to health care, thereby keeping enrolment low. Similarly in the Democratic Republic of Congo and Rwanda, long distance from health facilities and the absence of a doctor in the few health centres have been found to account for the low enrolment (De Allegri et al. 2006a).

However, distance from a health facility might be overridden as a limitation to enrolment where promotional campaigns and comprehensive health services for distant communities are provided at such distant facilities. In a study in the Nouna District, De Allegri et al. (2006a) found a commendable level of enrolment in the rural areas. The rural health facilities offered comprehensive benefit packages comparable to that offered in the higher order health care centres. These services included a range of first-line and second-line services, and emergency transport services. The study revealed that improvements and investment in health services delivery played a significant role of counteracting the possibility of distance acting as a limitation to enrolment.

Furthermore, inadequate knowledge about health insurance, available options and registration processes may account for low enrolment. Among informal sector workers in Kenya, low enrolment in the insurance fund is as a result of the above problem. The informal sector workers expressed that they were unaware that they could also contribute and become members, and that they thought the scheme was for the rich and formal sector workers (Mathauer et al. 2008). Again they pointed out that they did not know where and when to enrol, and that they had not

been approached by anybody to enrol. These groups felt excluded. Likewise, in Tanzania, a significant number of the uninsured revealed that they had not joined the Community Health Fund because they were not educated by managers of the scheme before it was launched (Kamuzora and Gilson 2006).

Furthermore, Basaza et al. (2008) documents that poor understanding of the rationale of health insurance may explain low enrolment. The study revealed that the Ishaka and the Safe for Health Uganda schemes in Uganda have experienced low enrolment rates due to the above identified problem. Some of the uninsured members in a study expressed that if an insured person did not fall sick before the membership period elapsed, it was fair that he was not asked to pay contributions the following year. As a result, retention in the schemes was low. Similarly, in Tanzania, some uninsured people did not understand why they should enrol when they were not sick (Kamuzora and Gilson 2007).

In the Provinces of Hai Phong, Ninh Binh and Dong Thap in Vietnam, Jowett (2003) found that enrolment is low among the communities which have established cohesive IRSNs. The uninsured, especially the low income groups, were less likely to enrol in public health insurance because they obtain support from their family and other community members.

However, a contradicting situation has been found elsewhere in Rwanda where the existence of solidarity networks rather foster cohesion and solidarity which enhances the understanding and acceptance of the health insurance scheme rationale, thereby accounting for the relatively increasing level of enrolment (De Allegri et al. 2006b). A point can therefore be made that the existence of IRSNs can either enhance or hinder enrolment into formal health insurance schemes depending on the context under study. Where it fosters the understanding of the insurance scheme rationale, enrolment is likely to increase. On the other hand, if it reinforces the desire for reciprocity and equal cost sharing, enrolment might be low.

Moreover, enrolment can be low if cultural beliefs negatively affect perceptions about risk and disease causation. Low enrolment has been found among groups which attribute disease causation to traditional beliefs. Such groups are likely to have a dual or multiple health-seeking behaviours. In a study (De Allegri et al. 2006b) some uninsured groups expressed that some diseases were caused by spirits and offended neighbours. Others expressed that paying for membership when one was not sick was like inviting sickness or buying diseases. The adequacy of traditional health care systems in this area was also identified as a reason for low enrolment

because it influenced the health-seeking behaviour of the uninsured that combined both traditional and formal methods of health care.

Closely related to risk perception is ethnicity. De Allegri et al. (2006a) found higher enrolment among the Bwaba ethnic group, an ethnic minority group which had a different risk perception about diseases. Compared to other ethnic groups, the Bwaba were more open and easily accepted new initiatives. This suggests that members of an ethnic group are likely to share the same beliefs and perceptions which can reduce enrolment if they are negative.

Community participation may also be influential, and its effect has been identified in the Ishaka and Safe for Health Uganda schemes. Usually insurance schemes which are not mutual are operated and managed without actively involving community members in decision-making regarding the fixing of premiums and preferences to be factored into benefit packages. Lack of community participation might reduce trust, and trust as discussed already is vital to enhancing enrolment (Basaza et al. 2008).

Interactions among the causative factors

Although the factors which have been discussed above might all or selectively influence enrolment differently depending on the situational contexts, they do not always operate as independent entities but may exhibit some dependencies. In other words, some are not mutually exclusive though they have been discussed as separately. Some factors may work cumulatively (one giving rise to the other), alternatively or in combination to produce a result which will influence enrolment. It is important to highlight some of the interactions among the factors to give readers an insight into how these factors reveal interdependencies.

Income as a factor which strongly influences the ability of individuals to pay insurance premium is linked to employment. The employed has the means to earn more than the unemployed. The low income earners, the unemployed, and those with no identifiable source of income are the least to have the means to pay premiums. This is why premium subsidy for the low income groups and the unemployed has been suggested (De Bock and Gelade 2012) as one of the means by which health insurance coverage can be increased.

Again, income is associated with education. Except in those advanced societies and welfare states where inequalities in education might not be highly influenced by the inequalities in

income distribution, the well-to-do are usually advantaged than the poor with regards to the affordability of the cost of formal education. Education has the potential to equip the individual with valuable skills and training which will provide the source of livelihood for earning income. However, education also involves cost. Therefore, it can be argued that the wealthy and their families are likely to have the ability to secure more avenues for raising incomes in unequal societies, whereas for the poor, the reverse might be true.

In addition, education links positively with the acquisition of knowledge, in this context, the understanding of the health insurance scheme rationale, risk-perception and health-seeking behaviour. A person who is not educated about the rationale and the benefits of health insurance is unlikely to enrol, unless influenced by others to do so. Knowledge about health insurance rationale entails an understanding of the principles of solidarity, risk-sharing and resource pooling. This implies that traditional societies with no formally educated members might prefer informal solidarity groups to formal health insurance schemes either because they are uninformed about the existing formal schemes, or because they do not understand or do not accept the principle of risk-sharing and solidarity which are important tenets of such schemes.

In every society, equity in resource distribution has an effect on income generation, wealth accumulation and human development (Carrin 2002). The more polarised resource distribution is, the higher the level of inequalities and poverty. This concept also applies in understanding the influential factors of enrolment. The mere introduction of a health insurance scheme in towns and villages might not be enough to achieve equity in the access to health care unless it is accompanied by equity in the provision of health facilities such as hospitals and health workers.

Often, rural areas are neither not the preferred locations for the establishment of hospitals which provide higher level health care, and the construction of good roads, or the priority areas for the deployment of skilled health workers. Consequently, rural communities face problems with accessing quality health care. Covering longer distances in order to access quality health care might be necessary but might also be a disincentive to enrolment and this arises out of the inequalities in resource allocation and distribution.

Community participation has the potential to positively influence enrolment as it builds solidarity and enhances the sharing of knowledge about the importance of membership enrolment. It might also strengthen trust in the management of an insurance scheme, especially where it is managed by community representative members. This suggests that the lack of trust and knowledge as disincentive factors to enrolment can be due to the absence of, or the low

level of community or membership participation in an insurance scheme design, management and policy implementation.

People's perception about diseases may relate to how vulnerable they are to illness and catastrophic cost of health care, and the cause of illness and this may be influenced by their level of education and accumulated wealth. People who perceive themselves as healthy might not see the need to enrol into health insurance, especially when they have high incomes and do not live in the fear of having to pay a high cost for health care at an unexpected period when they might have the least ability to pay. Likewise, when people attribute the causes of diseases to offended members of their communities (De Allegri et al. 2006b) or to spirits and unseen forces, it might be because their level of education on disease causation is low.

It should be noted that risk-perception and perception about disease causation influence health-seeking behaviour. If a person believes that the cause and cure of illnesses are searchable through scientific diagnoses and curative means, he or she is likely to use modern medicine provided at formal health centres. A person's perception about risk might be influenced by cultural beliefs and norms, religiosity and the level of education attained. One who attributes disease causation to unscientific forces is likely to use traditional medicine or consult faith-based and spiritual healers. In the example given, the former might patronise health insurance while the later may not.

Age and gender affect roles in decision-making to join or be exempted from a health insurance scheme. Ghana's NHIS provides premium exemption for some age categories (below 18, above 70) and pregnant women but require payment of the same amount for registration. Owing to this, higher enrolment might be found among those falling within the exempt age group than among those outside of it. Gender might influence the decision to enrol, especially in households where income and educational inequalities are manifest. Unless the insurance scheme design places those with the least influence over household resource allocation and use in an advantaged position, the more powerful (the one who controls and allocates the household resources), usually the head of the household, decides which members enrol. While the inequalities might not be an influential factor of enrolment in all households, it might be a pervasive and a major decisive factor especially in *de jure* and *de facto* households, households headed by credit constrained women, and those headed by uneducated women.

The perceptions about scheme and the quality of health service provision to the insured can be linked to administrative efficiencies. An efficient insurance scheme has management which

performs well to delight clients and attract new enrollees. One which faces managerial problems such as the inadequacy of skilled personnel, and the inability to create large risk pools can result in financial difficulties which have the potential to hinder reimbursement of service providers on time, and this can translate into poor service provision to the insured which also has an adverse effect on enrolment.

Administrative inefficiencies can lead to the implementation of unfavourable policies which do not encourage enrolment. For instance, high co-payments and deductibles might reduce the abuse of health services by the insured but it might also discourage enrolment by raising the cost of seeking health care with insurance. Either way, clients or insurance providers may gain or be disadvantaged. Gains by the insurance providers may lower cost and improve service provision, whereas gains by the clients (where there are no co-payments and deductibles) may raise the cost of operation for the insurance provider while increasing the desire of individuals to enrol. It is important that the balance between the differential interests is found in making decisions to increase health insurance coverage.

Having shown how some of the factors interact, it is important to stress that they have relative importance. Some exert a greater influence on enrolment than others. Employment type is significant but the income made is more important. Income determines the ability to pay and it can be argued as the most significant. It can also affect the level of risk aversion and the acquisition of relevant knowledge as discussed already.

Education can be placed above the access to information, knowledge, risk perception and health-seeking behaviour. The educated is more likely to have knowledge, a drive to enrolment. The perception about risk is more influential than health-seeking behaviour because it is the perceived health state of a person that directs the choice of health care method.

Cultural beliefs and religiosity have greater influence than perception about disease causation and health-seeking behaviour. Often than not, it is the norms and beliefs of a group which govern their way of life, their thoughts and the decisions they make. As reviewed, a particular group may buy insurance or not, as a factor of their characteristics.

Trust is earned. The benefits derived from a scheme have the power to build or create trust. This suggests that scheme efficiencies, equity in health infrastructure distribution, quality service delivery and community participation are more important than trust itself. Figure 1 shows the factors which affect enrolment, and the interactions discussed.

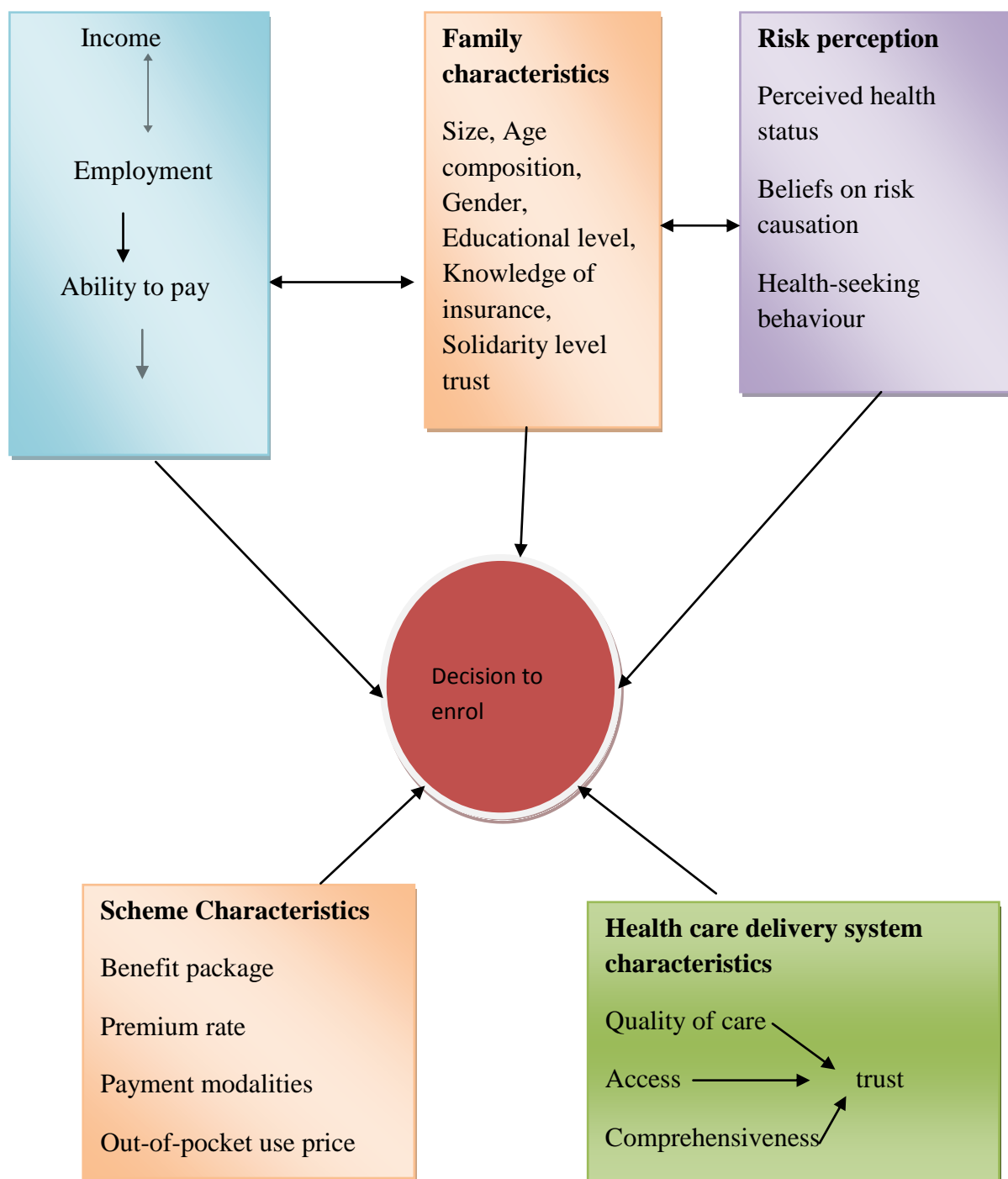


Figure 1: A model showing the factors which influence enrolment:

Source: Author's construct.

Theoretical framework

Theories of decision-making in the health insurance context

In this section of the thesis, I discuss the social and economic theories of decision-making and their influence on enrolment. Admittedly, some influential factors may fall beyond the socio-economic domain. However, I find these theories to be useful explanatory reasons, owing to the fact that a considerable number of the factors, majority of which have been discussed are well nested in these theories. The theories to be discussed are: the consumer theory and the theories of decision-making under uncertainty: the expected utility theory, the state-dependent utility, the endowment effect, the status quo bias, the regret and disappointment paradigms, the prospect theory and the poverty literature.

The consumer theory

This theory posits that consumers or the *economic man* as Edwards (1954) calls them always want to maximise the utility they obtain from a good and so given that they are well-informed, they will consume various goods knowing their relative prices, preferences and income. In effect, a change in the prices of such goods and the income of consumers affects the purchasing decisions and quantity of the goods that rational consumers will demand. Health insurance is perceived to be a normal good with a positive income elasticity of demand (Lancaster 1966). This means that a slight change in the price of health insurance produces a significant effect on its demand, in this context on enrolment. The implication is that an increase in the rate of premium or a decrease in the price of a health insurance alternative, user fees in this context, is expected to lower the demand for insurance. On the other hand, an increase in the price of user fees and a decrease in premium are expected to increase insurance demand.

The theories of decision-making under uncertainty

Unlike the consumer theory, the theories of decision-making under certainty do not only analyse the demand for insurance on the basis of the expected utility from health insurance membership, but also emphasizes that people enrol or not bearing in mind the uncertainties about their health in the future. For instance, will their health improve or worsen in the future (Schneider 2005)?

The expected utility theory

This theory is based on the principle that the decision to buy health insurance is dependent on a choice that the individual has to make between the uncertainty that there is a probability of incurring a loss when ill and uninsured and a certainty about a loss that will be incurred for being insured through premium payment (Schneider 2005). Under the expected utility theory, people do not like to take risk (are risk-averse), and they consider carefully making decisions which will have adverse effects on their wealth. They usually prefer an alternative which offers financial protection to one which drains their wealth.

When a choice has to be made between purchasing health insurance or not, people might be uncertain as to whether they will fall sick or not, and whether they will benefit from being members or not. However, insurance can reduce the uncertainty about losses. Schneider (2005) identifies that whether ill or not, the purchase of a health insurance helps to level income and improves certainty. In an event of illness the insured has a greater potential to maximise utility than the uninsured. This implies that the demand for health insurance is influenced by an individual's level of certainty and aversion for risk. As a result, the higher the aversion for risk, the more likely an individual is to purchase health insurance.

Even though the theory offers useful background knowledge which serves as a reference for analysing enrolment, some inherent shortcomings have been identified. Propper (2000) posits that it does not give room for the discussion of the effect of income of consumers on the choice of health insurance in the situation of certainty. In a study of the demand for co-existing private and public health insurance, Propper (2000) found that patronage is influenced by income, population characteristics and the quality of health care provision. This study is consistent with the consumer theory.

Another limitation of this theory has been identified by Schoemaker (1982). This study showed that the use of choice behaviour for explaining enrolment is insufficient, and those additional factors such as the societal context about what is regarded as good behaviour, and regret considerations are important decision-making factors. To Schoemaker, it is not only the aversion for risk which influences the demand for health insurance, but also the accessibility impact of health insurance. The author argues that accessibility refers to the gains that medical care will be available to the poor when insured, but will be unaffordable (inaccessible) to the uninsured. In other words, the poor will insure because they will have a higher access to health care than when they are uninsured. Without health insurance, the poor will be unable to seek expensive health

care, especially when money lenders are unwilling to assist them with loans due to their credit unworthiness. Although these criticisms stand, the expected utility theory is still useful. Moreover, other theories of decision-making, some of which will be discussed, have emerged to fill the loopholes.

The state-dependent theory

According to this theory, the utility that consumers derive from health insurance, as well as their preference are influenced by their state or condition at the time of making the choice. For instance their health status might be good or bad, and they might have higher or lower incomes. Consequently, people react differently with regards to risk-taking. While some will be risk-averse, others will prefer to take risk. The state of the consumer and the magnitude of the expected pay-off from insurance can influence the decision to enrol or not (Schneider 2004). A healthy person might anticipate remaining healthy in the future, in which case he or she may not insure or choose an incomprehensive insurance package since the expected payoff will be low. This means that the magnitude of the expected insurance pay-off, and the state of an individual influence the decision to purchase insurance.

This theory gives greater weight to the state of the consumer and the expected pay-off from an insurance membership than to income. A study confirming the applicability of the state dependent theory has been offered by Manning and Marquis (1996). In their study of the demand for health insurance, they sum the value of medical care that will be obtained with insurance, and the cost of the risk avoided in the utility function of the insured. Their results review no correlation between household income, premium levels and enrolment, but rather a positive relationship between enrolment and the expected pay-off that the insured will receive when sick.

Their findings further suggest that even at lower premiums people may not insure if they expect less pay-off from health insurance when they are sick. They may anticipate that they can spend less on treatment when they fall sick in the future by purchasing medicine not covered by insurance for self-treatment. The rich may also not insure because the value of the expected pay-off might not be equal to the quality they want, in which case their preference will be to seek more expensive and a higher quality health care through private health insurance or by paying user fees.

The prospect theory

The prospect theory challenges the underlying assumptions of the expected utility theory which analyses insurance uptake based on the concept of uncertainty and risk aversion. The theory argues that the decision of individuals to enrol into health insurance is from a gain or lose perspective rather than from uncertainty. In this theory, every individual assumes that there is an optimal level for risk, and that at this level gains or losses can be made. This optimal level influences an individual's decision to enrol and it serves as a reference point from which unhealthy choices which lead to losses can be identified and judged. People are usually motivated by gains to enrol.

Below are examples to illustrate how this theory influences an individual's enrolment decision: A healthy person might perceive to remain healthy for a long time and will not insure bearing in mind that enrolment will not be beneficial as he might pay less on health care without insurance. If such a person falls sick eventually and spends more than he would have spent on health care with insurance, then he has made a loss. On the other hand, one who insures because of a perception that his health might get worse gains if he actually pays less for health care with insurance than he would have done without it. In the examples given, there is an evidence of risk as a deviation from the perceived future health status might cause greater losses than the individual expects. Therefore, the prospect theory argues that regarding losses, individuals prefer to take risk and that they will insure only if they are certain that losses will be incurred in the future but not because they do not want to take risk (Schnieder 2004).

The study by Marquis and Holmer (1996) supports this theory. In their findings, insurance premium did not affect the decision of households to enrol but rather their risky prospects. It was found that risk levels lower than USD 200 were regarded as unimportant and that this amount served as a reference point from which people evaluated gains and losses. The prospect theory offers useful insights into how risk assessment and gain motives influence the decision to enrol, but does not reveal any relationship between household incomes and how it is affected by the deviation from an expected health risk.

The cumulative prospect theory

This theory explains the demand for health insurance based on a combination of the concepts of the state-dependent theory and the prospect theory. According to this theory, people give various weights to the probability of an eventuality occurring. Some events might be assigned higher weights of losses or gains than others. Guided by the gain motives, people choose between those probabilities which have the highest potential to bring gains. However, often people tend to underweight high probabilities and overweight small probabilities (Wakker and Tversky 1993). Those who demand health insurance overweight the small probability that they will fall ill and make losses, whereas those who do not insure underestimate the high probability that they might fall sick and not insuring can cause them a lot of losses. Often it is the poor who tend to underweight high probabilities because of the greater need to meet other basic needs such as food and shelter, thereby remaining uninsured (Schnieder 2004).

The endowment effect theory

The endowment effect theory states that in making decisions about enrolment, individual choices are affected by the aversion for risk towards accepting something new, in this case the acceptance of health insurance which means forgoing the payment of user fees. This risk aversion arises from the fact that one might doubt whether accepting a new idea will be more advantageous than sticking to an old and an accustomed one. According to this theory, people usually have the perception that there is greater cost in giving up an old idea or practice than the benefits that can be obtained from adopting something new. In effect, Kahnemann et al. (1991) argue that people will be willing to charge a higher cost for something they are giving away but will be prepared to pay lesser for the same good. Normally, they will prefer not to give away the old things they have in their possession, especially when they are not sure of the benefits of accepting the new.

Deducing from the underlying principle of this theory, the poor will enrol if they perceive that health insurance gives more benefits such as improved access to health care, reduced cost of health care and financial protection against the health care expenditure. However, they are unlikely to enrol if these benefits are not guaranteed, unrealistic, or if higher costs are incurred with co-payments and additional charges for quality health care.

The status quo bias theory

This theory shares a conceptual similarity with the endowment effect theory in that it also explains the decision to insure from the point that people often like to stick to the status quo; an accustomed way of doing things, than to accept an unknown and unfamiliar innovation (Kahnmann et al. in Schneider 2005). The preference to stay with the status quo originates from the fact that people perceive a deviation from the known as more detrimental than the benefits of the unknown. The desire of individuals to stay with the status quo is higher when there are a variety of complicated alternatives to choose from (Samuelson and Zeckhauser 1988). Linking this to the decision to enrol, the presence of numerous competitive health insurance schemes may confuse consumers in their ability to make a choice, in which case they might prefer to stick to their old ways of seeking health care.

This theory again emphasises that consumer information plays an important role in the decisions to enrol, especially when introducing health insurance to a group of illiterates with scanty or no understanding of the concept of insurance, and the poor. It argues that the desire of people to stay with the known is higher when they lack sufficient information on the numerous available options. In this case, the lack of information or the *veil of experience* as Schneider (2004) calls it becomes an important ruling determinant of choice.

Regret and disappointment theory

This theory explains the decision to enrol by expanding on the state-dependent theory. According to this theory, not only does the state of individuals influence their decisions to insure, but also their aversion for risk and conservative preferences. In contrast with the expected utility theory, this theory argues that in making decisions to insure, people do not only consider the outcome of their choices but factor in their desires to avoid regret and disappointment. Regret may be felt in case the decision made yields bad or more costly results such as paying more for health care without insurance than one would have paid with insurance. Disappointment is also felt when the outcome of the decision is a deviation from what was expected, such as receiving less quality health care with insurance than one would have received by paying at point of service. In essence, people may not insure because they might regret using health insurance, or they may feel disappointed when they obtain less benefits from insurance. They may also insure to avoid regretting the possibility of falling ill and paying more for health

care because they are uninsured, or to avoid the disappointment of receiving poorer health care without insurance than they would have received with insurance.

This theory offers important additional explanatory factors to the state-dependent theory in explaining the decisions to enrol. However, it fails to bring out any difference in the amount of regret and disappointment between the poor and the rich (Looms and Sudgen 1987). For instance, the poor may not insure because they have higher amounts of the possibility to feel regretted and disappointed with insurance than the rich, or the rich may insure because they are less likely to feel regretted or be disappointed by less payout from insurance because the effect of this on their incomes might be insignificant.

The poverty literature

This theory explains that the decision of a household to insure is influenced by time preference and poor households' aversion against risky investments. According to this theory, as households continually experience a drop in income, or move closer to the level at which they can be classified as poor, it is expected that their aversion for risk also increases due to the fear of having to live below the survival level following a further drop in their income (Wagstaff in Schneider 2004). The poverty literature points out poor households as those which are more likely to experience credit constraints in the future. Owing to this, they are also the households which might be more willing to give up current consumption to invest in insurance.

The concept of the time preference is that the households which will invest in health insurance are those which have a higher preference or value for future protection than they have for present consumption. Even though poor households are expected to have more aversion for risks, the literature is quick to point out that on the contrary, they might not insure due to the pressure and the necessity to satisfy more basic needs such as food and shelter.

This theory adds that the decision to enrol may also be influenced by the desire of households to handle future risks with alternative risk mitigation mechanisms. For instance, instead of enrolling into formal health insurance, they may join informal organisations which assist members to cope with risks, diversify their sources of income by engaging in trading, farming, and livestock rearing. They may build up capital for more income generation through savings. Others may borrow from friends and relatives, the credit market or money lenders. Townsend

(1995) adds that poor households may also educate one of their members hoping that they become wealthy and assist in taking care of the financial needs of the rest of the family members. Better still, they may distribute the burden of risk among family members by involving non-working members like children and women in income generation activities.

In agreement with the poverty literature, Jowett (2003) argues that in the absence of informal risk-coping mechanisms, poor households are more willing to enrol into public health insurance. These mechanisms may be helpful to the poor when they cannot afford premiums; however, they are unsustainable and have limitations (Aboderin 2004, Schneider 2004). The poor might not be able to secure credits from the credit markets due to their inability to provide collateral.

The results of a study in Rwanda (Schneider and Diop 2001) on the insured and uninsured revealed that other factors in addition to time preferences and poor households' aversion against risky investment may better explain the decision to enrol. The study revealed no relationship between socio-economic background and enrolment; rather it revealed that enrolment was more affected by geographic variables such as the district of residence of the participants and the distance from a health facility. The findings suggest that households belonging to different socio-economic groups may have similar or no significant difference in their levels of risk aversion. Therefore, it is important that additional factors such as the distance from a health facility, and trust in health insurance providers along with the aversion against future risks are considered.

Chapter summary

In this chapter, I have presented the theoretical perspectives of this study. Since the objective is to examine non-enrolment, I have reviewed literature touching on the general determinants and of the factors which influence the uptake of insurance. I have argued that some of the factors may be more important than others, and not all the factors apply in all geographical contexts. Still, the factors do not work exclusively or separately as they have been treated, but that they may operate cumulatively or in composition, sequentially or alternatively. The theories of decision-making have been discussed. This and the literature will be used as an analytical framework against which the thesis's findings will be examined.

Chapter four

Methodology

The methodology of a research work defines how the research objective can be achieved and focuses largely on answering the research question specified. In order to answer my research question, I carried out in-depth interviews with the uninsured and previously insured members of the NHIS. The fieldwork lasted for a period of seven weeks, from June to August.

In conducting the fieldwork, I used the qualitative method. Several issues informed the choice of this method over the quantitative method. I realised that I had gained much knowledge and practical experience from course work, and as such could feel more at ease with this method. Even though I had some knowledge in quantitative method, I felt it was inadequate to carry out the research using this method until I had received further training. Considering the limited time allocated for the fieldwork (two months), time constraints could not permit this. Although I was familiar with the study context in general, my interest was to find varied responses which meant that I had to purposefully select my informants for the study. Opting for a qualitative method was rightfully suited to achieving this. Moreover, several research work on enrolment into health insurance schemes have used quantitative method, employing the measurement of socio-economic variables such as income, age, employment, level of education and distance from health facilities (Dong et al. 2004a, De Allegri et al. 2006a, Sarpong et al. 2010). In order to explore the topic in the broader sense, unrestricted to measurable variables but to discover varied experiences and interesting opinions, I chose the qualitative method and the interview technique.

"Qualitative method concentrates on elucidating human environments and experiences within a variety of frameworks, the environment being the social structures which affect the behaviour of the individual and vice versa." (Hay 2010: 5)

Qualitative research is argued to be intensive and flexible, that is, searches for variations in meaning rather than trends, standardised methods, regularities and patterns which are characteristic of quantitative methods (Cloke et al. 2004). Owing to this, qualitative researchers are able to operate in a natural setting, thus live within the daily experiences of the people they study to be able to understand how they behave, why they behave in a particular way and to evaluate the findings in a sensitive but unbiased manner.

Admitting that the researcher's interaction with the study objects or population can have an influence on his findings, critical reflexivity, defined as a conscious effort by the researcher to constantly scrutinize himself throughout the process of the research (Hay 2010) is vital. I intend to cover these issues throughout my research process, from the choice of a research topic, preparation stage, selection of informants, gaining entry, ethical considerations, and the conduct of my interviews and the trustworthiness of my research. I will as well bring out some of the problems and challenges I encountered and what informed the choices I made in order to overcome these challenges. I should be quick to point out that the research process though planned prior to the fieldwork was never one which followed a straight path. I constantly went back and forth, making adjustments where necessary whilst on the field depending on the assistance and resources at my disposal at any given time, and also on the realities on the ground.

The process of the research

The preparation stage

In the initial stages of my preparation, I had a feeling of uncertainty. This revolved around the fact that I had chosen a topic but with no specific study site in mind which could be appropriate for the study and its objective. The thought of the possibility of a null case continually aroused my fears. Nonetheless, I knew that I could never compromise on conducting a research which gave a true reflection of the realities on the ground irrespective of the time constraints. I had to prepare for all kinds of eventualities such as changing the research objective, the study area or even the research topic where it became necessary. Flexibility was therefore of utmost importance.

In order to allay my fears, I had to read extensively on health insurance. I found that there was a lot of literature on this topic on most of the developing countries which could be beneficial. Although results of research findings may be context specific and not general, in my case I found that the literature from various geographical regions could provide in-depth knowledge for developing an analytical framework for my study. Most importantly, studies from countries in the sub-Saharan Africa region such as Burkina-Faso, Ghana, Kenya, Nigeria and Uganda were useful, attesting to the issue of low insurance coverage. However, I should state that it was difficult getting adequate specific literature on regional and district level enrolment in Ghana. I

found consolation from reading some reports by the Ghana NHIS. Reports and articles from the WHO were equally helpful.

Bearing in mind that different geographical settings present varied opportunities and differing challenges, I read on the districts and regional profiles of 6 out of the 10 regions in Ghana, all in the southern part. My focus was on the geographies, economies, disease burdens, population, social amenities and poverty levels because I felt these could be significant for my thesis. Through these readings, I found that the Kwahu South District, one of the districts in the Eastern Region of Ghana could be an interesting site for my study.

Preparing for the field work required that I established contact with my potential informants, agencies, institutes and bodies which could be helpful in this regard. My first point of call was the Okwahu South Health Insurance Scheme (OSHIS), the representative scheme of the NHIS for the Kwahu South and Kwahu East Districts. I found this scheme as an indispensable source of vital information for my study as it operated closely with the NHIA, and saw to the implementation of nationally made policies at the district level. The scheme dealt directly with all communities within the two districts aforementioned. I made initial contact with the scheme manager through email and phone calls. I also contacted the local assembly for the kwahu South District through emails upon finding that I could have access to statistical data and information pertaining to the district profile from the assembly. These two agencies of the government coordinated with each other and carried out research into developmental policies and prospects of their implementation in the districts under their jurisdiction.

I made my contacts formal upon arriving on the field and handing in an official letter I had obtained from the Department of Sociology and Human Geography, University of Oslo. Even though the letter stated clearly the purpose of my study, I introduced myself and reiterated the reason for my study severally at any point I needed assistance. I had the opportunity of working closely with the public relations officer, registration officers and the scheme manager for the OSHIS as well as the planning department of the Kwahu South District Assembly. For instance, I followed the registration team to the field on an occasion where a mass registration exercise was carried out. In the process, my observations, interviews and informal conversations with them gave me some valuable information. I also gained contact with some insurance registration agents in the various communities.

Choosing the study site/area

After I had arrived on the field, I had to find out which area would be appropriate for my study. I was interested in choosing sites which would bring out variations in my findings, while at the same time impose the least limitations to the research. I sought assistance from the district assembly but was referred to the OSHIS. Since my objective is to find the reasons for non-enrolment, I thought it was on point to request for statistical data on specific enrolment for the towns and villages under the district's jurisdiction as a reference or study guide for the selection of my study sites. However, I realized that I had to adopt a new approach upon being told that the OSHIS did not have retrievable records on enrolment rates. Besides, bureaucratic processes had to be observed if I could get the required data from the regional or national officers, but to this no assurance was given.

Through informal conversations with the registration team and the public relations officer at the OSHIS, I discovered that since the introduction of the NHIS, the OSHIS has registered about 50% of the population within the district. This figure did not readily give an overview of which areas recorded the least enrolment rate; nonetheless, it gave me the assurance that there was the possibility of finding out which site could be suitable for my study. I also found out about some communities which had identifiable groups which were not enrolling. The OSHIS manager assisted in my choice of study sites by mentioning to me some communities where enrolment had been consistently low. I gathered that most of these areas were deprived villages and thought that more of the uninsured could be easily found in the rural areas.

However, bearing in mind that my interest was to find varied opinions, I decided not to limit myself to the deprived communities, but also choose those areas which could offer interesting findings such as those towns and villages which had varied economy, culture, religion and geography. I took into consideration accessibility to health centres and registration points. With this, the district assembly assisted by giving me the profile for the district. This gave me a fair idea of the endowed and less-endowed areas in the district. I visited some of the towns and villages which were suggested by my informants. Some of these villages had bad roads and it rained often making them inaccessible. I was however not in a haste to choose a site immediately after a visit. I finally settled on the sites to include in my study after I had reviewed the interviews I conducted on the field, choosing those areas which offered interesting findings.

I chose to include eight areas; these were: NKyenenkyene, Pitiko, Kotoso, Okra Adjei, Kwahu Tafo, Asubone, and Adawso. The locations of these areas have been shown in figure 2. The

areas represent culturally, politically, socially, geographically and economically dynamic sites. Pitiko is a village inhabited mainly by three dominant ethnic groups: the Adas, Kwahus and Ewes. Although the land originally belongs to the Kwahus and falls under the authority of the Kwahu paramount chief, there were three chiefs in this village, one for each group. Adawso and Kotoso are towns which serve as trading centres for most of the surrounding villages across the Afram River, a tributary of the Volta River.

Accessibility to some of the towns is facilitated by the River as well as an asphalted road linking them to the district capital. Pitiko is a village lying further away from the district capital but linked to it by a dirty and winding third-class road which sometimes becomes difficult to ply on when it rains. It has a community health post but no hospital. All the selected sites have populations of varied characteristics. The dominant occupations are informal workers and self-employed: mainly small scale farming, fishing, and retail trading. The few formal sector workers are in the public service sector.

In as much as I was keen to select those areas which could be interesting, there were some challenges which in my view limited the study in a way. I gathered from my interviews that those rural areas across the Volta River could have quite a significant number of people who were not joining the scheme. Upon paying a visit to the Kotoso Reproductive Health Centre, I was informed by the health officers that many of the uninsured patients they received resided in villages across the River. However, I could not visit these places because I found out that one could embark on a return trip by vehicle only when it was a market day in the towns. There were small boats and canoes which commuted between these villages on ordinary days but I figured it was unsafe to use them as they were old and not in good shape. Besides, the rainy season had set in and it rained heavily often.

Nonetheless, these villages had similarities with those sites I had selected for my study thereby giving justification for my choice of the convenient sites. I realised that they are similar in terms of ethnic composition, occupations, geography, opportunities and constraints. There is no evidence that the villages I did not choose were the most appropriate for the study and that they would have brought entirely new findings. Besides, time constraints would not have permitted a large scale study, and also since my interest was not in producing findings which could be generalised, there was no point studying an array of sites with no differing characteristics.

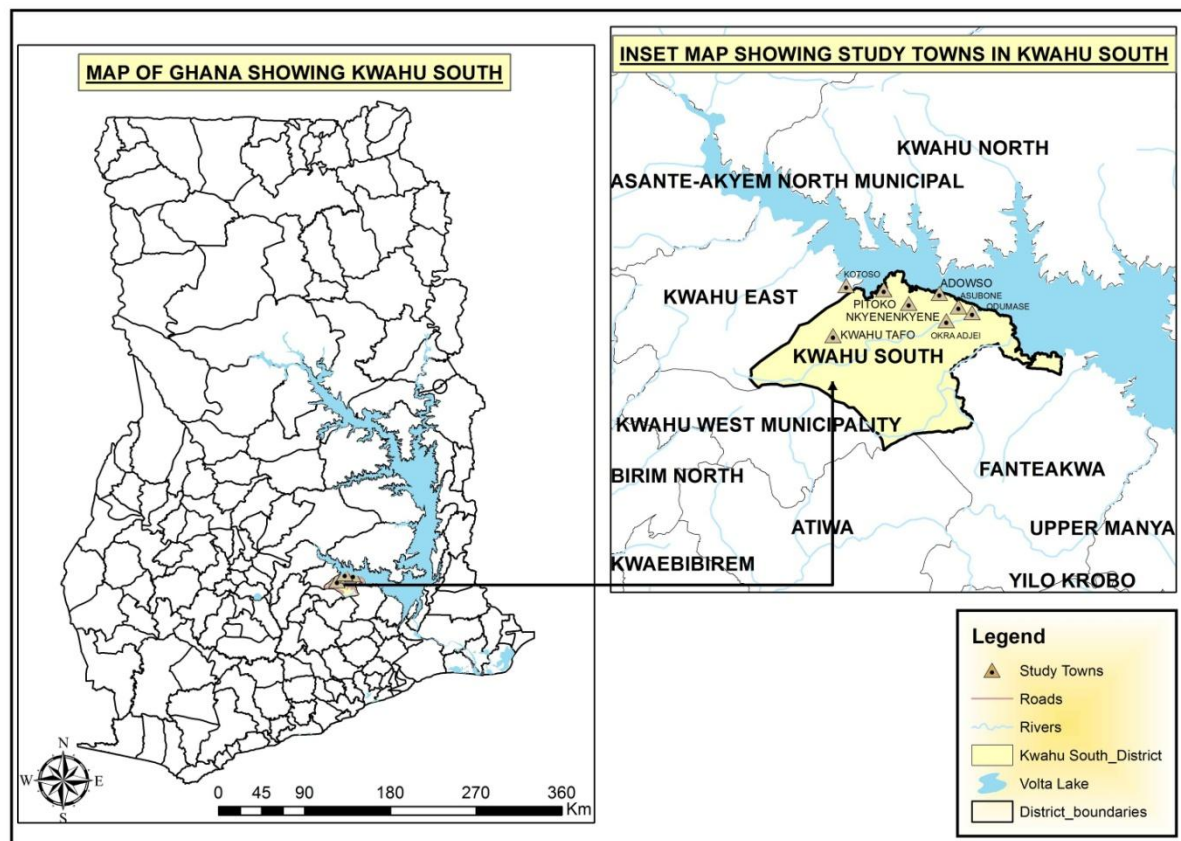


Figure 2: A map of Ghana showing the study areas

Source: Centre for Remote Sensing and Geographic Information Systems (CERSGIS 2013).

Gaining access

An important aspect of every research work is how to negotiate entry or gain access to the sites as well as the people who have the relevant information for the research work. In negotiating entry, the researcher may need to draw on all the resources, such as social networks and information available at his disposal, as it is a matter of practice with likely challenges which can determine the success of the research work. Equally, an understanding of the conceptual or theoretical knowledge underpinning the research is required and the researcher should abreast himself with knowledge pertaining to the people or sites he wishes to study. This helps to understand the social structure and organisation of the setting, as well as the possible obstacles in the path to gaining access and how to overcome them. As Hammersley and Atkinson (2007: 41) put it:

"In many ways, gaining access is a practical matter... It involves drawing on the intra-and inter-personal resources and strategies that we all tend to develop in dealing with everyday life. But achieving access is not merely a practical concern. Not only does its achievement depend upon theoretical understanding, often disguised as 'native wit', but also the discovery of obstacles to access and perhaps of effective means itself provides insights into the social organisation of the setting or the orientations of the people being researched".

Although it is possible to anticipate problems prior to gaining access, the challenges are more likely to unfold after entering into the study setting and in the process of the research, as it was in my case. Since I hail from the district where I conducted the study, I felt I had adequate knowledge about the culture of the people and how they are socially organised. The general perception is that the Kwahus are cooperative and helpful in giving information out, especially where they are assured that it has no politically motivated interest which carries a threat.

I decided to conduct a pilot interview at Nkwatia, a town in the district, prior to the start of my actual interviews with the intention of finding out how best I could approach my informants and receive a warm reception. It was through this exercise that I met people who knew a lot about the sociological settings of some of the places I had decided to conduct my research. Through informal conversations with an informant, I got to know that I could get some of my informants if I visited the health centre in the town; however, they were unlikely to be cooperative for the sake of confidentiality of information given unless the superintendant health officer introduced me to them. It was then that I discovered that the norm of encountering *gate-keepers* was necessary to ease my research.

Gate-keepers are people who can grant or withhold access to informants. These people consider themselves and others consider them to have the authority to refuse or grant access to the research setting and, or informants (Hammersley and Atkinson 2007). Even though I was not conducting my research purely in an official setting, I realised that seeking the consent of some people in authority was necessary. In my case, I should say that there were two identifiable groups of gate-keepers and seeking the consent of each of them was necessary for me to gain access to the study sites and to the right informants. These groups could as well preclude access. These were the chiefs and the OSHIS officials.

I sought the consent of the OSHIS officials. They gave me an approval and a recommendation letter but also informed me that it was good that I consulted the chiefs and asked for their

approval to conduct my interviews, particularly in Pitiko where there was a looming and a long standing chieftaincy dispute. I consulted all three chiefs to avoid being *tagged* as a spy from one group against the other. I gained their approval after I had shown them my recommendation letters from the University of Oslo and the OSHIS. These letters I also showed to the health officers at all the health centres I visited. Through my encounter with the OSHIS, I also realized that the registration agents in the communities within the districts could be very supportive in gaining access to my informants since they worked directly with the OSHIS by registering people within their communities on behalf of the scheme. As such, they knew well most of the community members who were insured and those uninsured. I requested for the contacts of all the registration agents in all the communities under the operations of the OSHIS. Having done this, I established contacts with some of them through phone calls, arranged an appointment and sought their assistance to identify my informants.

Challenges with gate-keepers

In as much as gate-keepers might be helpful by granting access, they may equally be concerned about the research and how it can affect them, usually with an interest of ensuring that the research paints a good picture about them, or put them in a favourable light. In this way, they might want to direct the focus of the research, exert some control over it or block access to some aspects of it (Hammersley and Atkinson 2007).

As I encountered gate-keepers, some challenges which could affect my research became significant. One, there had been a growing association of politics, local governance and chieftaincy in the study district and this had the potential of motivating these gate-keepers to pursue their interest in the research. Having made mention of the chieftaincy dispute at Pitiko, I also found out that the OSHIS was about to start a mass registration exercise in certain areas within the district, following a directive received from the NHIA to reach a set target. In view of this, they suggested that I conducted my study in some of those places where they would embark on the exercise. This conflicted with my interest as I did not perceive that those places would offer the most interesting research findings. Some members of the registration team persistently asked how many people I wanted to interview but I kept to my grounds that my interest was in getting varied opinions from interesting settings for the study. I figured out that they had an

interest in finding numbers, probably to guide them as to which areas to target for their exercise and in writing their reports.

The personality of the agents could also have an effect on who accepted to talk to me and who did not. The agents are usually people who live within the communities where they serve as agents. As such, they are well known by the local people. They could be associated with a particular political party, a religious or an ethnic group which has sympathisers and opponents. This implied that their personal characteristics, behaviour and relationship with others within their community could contribute to what kind of people they could suggest to me. There is the possibility that they point to those they are in good terms with, leaving behind those they have bitter relationship with.

Another problem I encountered with the registration agents was that they had contacts with some of the insured but not with most of the uninsured or the previously insured, especially in the towns where the population was quite large and there was more than an agent. Besides, some people registered directly with the OSHIS and not with the agents. This meant that they had limited knowledge about those who were registered within their communities. My approach to overcoming these challenges was to choose the leeway between identifying informants for myself and allowing the insurance registration agents to choose informants for me. I did not approach any of my informants with an agent. What I did was to have an informal conversation with them, asking them to brief me on their observation about enrolment in their community. For instance, asking them whether they have registered more females than males, elderly than the younger and youthful or formal sector workers than informal sector workers. In the end, their responses helped me to select informants who had relevant information.

Recruiting informants

In quantitative research, sampling indicates the technique the researcher uses to get respondents for his research questions. Various types of sampling techniques exist for quantitative studies; however, they all have a commonality of being non-purposive. This means that the researcher does not attach importance to what qualities are characteristic of those he decides to include in the research, rather, he aims at standardising the method used for sampling respondents. The respondents could be picked randomly. However, the number of people sampled is of essence to

the researcher as the objective is usually to come out with findings which can be generalised or applied to a larger population (Hay 2010).

On the other extreme, an important tenet of qualitative research is that the researcher aims at including people who have depth of knowledge, the right attributes and experiences relating to his research interest. Of utmost importance is a focused research interest, a grounded knowledge and background information. This aids to decide rightly on who to involve in the research and why (Hay 2010). From the foregoing, it is evident that the researcher should *select purposively* his informants but not sample randomly. As Hesselberg (2013) points out, it is better to use the phrase *selection of informants* for qualitative studies and *sampling of respondents* in quantitative studies. Qualitative research work involves interaction with people either as participants or informants. The number or how many to interview is not the focus of interest in qualitative studies but rather the question of 'who is it that has the experiences, perspectives, behaviours, practices, identities, personalities, and so on, that the research questions will require to investigate (Mason in Hay 2010).

Hay (2010) makes explicit that in qualitative interviewing being able to conduct interviews with a small number of the right people willing to share their experiences will provide useful insights into a research issue. In my case, to be able to select the right informants for my research, I constantly kept referring to my research objective which is to find reasons for non-enrolment into the NHIS in the selected study areas. I realised that two groups of informants could provide in-depth information necessary for achieving my objective. They stand out clearly as relevant informants. These were those who had never joined the scheme, and those who were previously members. Key informants for my interviews were the officials and staff of the OSHIS and the health officers in the health centres where the study was conducted.

My technique for choosing informants did not follow a strict path but was adjusted to fit well into each study context. I identified my informants by having casual chats with people in the streets, homes, and public places such as game centres. What I did usually was to first seek permission from the chief of each study site, after which I met with an insurance registration agent for a conversation about observation on enrolment in the community of operation. The information I gathered guided me as to which category of people to target or select for my study.

Since my interest was to gather variations in responses among informants as much as possible, I often made guesses, paying attention to those characteristics which in my view would provide

varied responses, such as age, spoken dialect, gender, physical health state, and type of housing in selecting my informants. With regards to age, I guessed what age range a person could fall between. My interest was to find informants falling within childhood, youthful or adulthood and aged categories, the reason being that these groups of people might have varied responses due to their varied health needs. In most communities in the district, different ethnic and religious groups often segregate or confine themselves to a particular geographical area. For instance, there were *zongo* communities which are areas of Muslim settlements in all the sites where I conducted my study. This served as an advantage for me to easily identify and recruit informants on the basis of religious affiliation, mainly Christianity or Islamic Religion. There were also migrant Fulani settler communities. It was quite easy to identify the different tribes by dialect, and because they are also confined to specific areas within their communities. Having identified the locations of these groups in the study sites, I set out to find people who were uninsured or previously insured for my study.

At other times, the insurance registration agents suggested people whom they knew were not members of the scheme. Usually, I approached a potential informant alone. I did this to avoid the possibility of my informants thinking that the agents might disclose whatever information they give to others, or provide information which might not be true about them.

With the exception of Pitiko where I figured that chieftaincy disputes had created factions among the population which could adversely influence the willingness of people to participate or give true information, I found that generally the registration agents could be more useful rather than exert negative influence on the research. In this village, I realised that if I requested for assistance from an agent, he might suggest people with whom he shares the same affiliation. To avoid this situation, I relied on the information about observation on enrolment trends which I obtained from the OSHIS to select informants from this village.

In all study locations, I also employed snowballing, defined as a technique whereby a chain of informants is created as the researcher identifies cases of interest or people involved in similar cases reported by others known to them who have participated in the study (Hay 2010). Some of the informants I interviewed were those who had been suggested by others who were either uninsured or previously insured and had participated in the study. Even though this technique saves the researcher the time he would otherwise use to go round and look for informants, it also has an inherent weakness which could affect findings of the research. There is the fear of missing out on more interesting issues from people with different orientation and experiences as

the informants who would be suggested are likely to have the same traits, characteristics and experiences as those who suggested them. Moreover, some people usually neighbours willingly selected themselves to be interviewed, especially when the interview was conducted in an informant's home. As Hammersley and Atkinson (2007: 104) point out:

"While often welcoming self-selection and perhaps even selection by others, the ethnographer must try to retain the leeway to choose people for interview. Otherwise there is a grave danger that the data collected will be misleading in important respects, and the researcher will be unable to engage in the strategic search for data that is essential to a reflexive approach".

To mitigate these challenges and minimise their effect in my findings, I included those informants with varied identifiable characteristics such as age, occupation type, religious and ethnic affiliation, from those they were suggested by, rejecting those with whom there was little or no variance. Though I equally gathered useful information from some self-selected informants, I was conscious of the possibility of misleading information.

Interviewing

The technique of interview is one which is important in qualitative research because of some inherent strength. Hay (2010) identifies the following as benefits of interviewing: helps to fill a gap in knowledge that other methods such as observation are unable to bridge effectively, investigates complex human behaviours, gather diversity of opinions and experiences, as well as provide insights into them, but again reveals consensus on some issues. Since my research objective is one which dwells much on gaining insights into individual opinions and experiences as much as possible, I realised that the interview technique was best suited to the study.

An interview has been defined as a form of verbal interchange in which the interviewer attempts to elicit information or gain insights into the opinions of the interviewee (Maccoby and Maccoby in Hay 2010). In this regard, it has been described as a *conversation with a purpose* (Webb and Webb in Cloke et al. 2004). Since it is more than an ordinary chat, the researcher should focus the interview as much as possible to acquire the maximum amount of information from each chat, in other words, reach a *point of saturation* of views (Hesselberg 2013) where he realises that he is getting no new experiences or expression of opinions from informants.

Three major forms of interviewing have been identified: structured, unstructured and semi-structured. Matthews and Ross (2010) identify that the three forms can be placed in a continuum, the semi-structured type falls in the middle place while the structured and the unstructured types lie at both ends. Structured interviews are those which have predetermined and standardized set of questions, thereby necessitating the use of an interview schedule (a set of carefully worded questions). The interviewer asks the questions in almost the same manner and the interview is question-based. Unstructured interview on the other hand has been described by Hay (2010) as informant-focused in the sense that it does not rely on standardised set of questions, thereby giving the informants a lot of flexibility. Hay describes semi-structured interviews as those which are organised around some degree of order but at the same time permit a greater level of flexibility. They are content-focused because the questions asked are those the interviewer deems relevant to answering his research questions. An interview guide (a list of the issues the interviewer aims to cover) is often used. I chose to use the semi-structured interview due to some reasons. In agreement with Matthews and Ross (2010) the method is suitable for the:

"collection of qualitative data when the researcher is interested in exploring people's behaviours, experiences, understandings and how and why they understand and experience the social world this way". (Matthews and Ross 2010: 221)

I realised I did not have much time available to conduct a pre-test on an interview schedule if I wanted to use a structured interview. Similarly, the unstructured type requires thorough preparation which is equally time-consuming. It requires that the researcher is experienced and fully abreast with earlier events, places and the informants (Hay 2010) otherwise, there is a greater possibility of the interviewer losing control over the interview. I deemed the semi-structured interview as the most convenient type which would help me follow interesting leads in the process of my interview due to the flexibility it offers, while at the same time ensuring that there is some form of order to help keep to time. I prepared an interview guide, with the objective that it would help me not to miss out on some issues I intended to discuss.

My interviews were conducted within a period of four weeks. Most of my interviews lasted between thirty minutes and an hour. Overall, twenty-three interviews were conducted including four key informants, all of whom have been referenced in the appendix of this thesis. As explained earlier, the first three weeks of my field work was spent on preparation: securing entry, identifying potential informants and scheduling interviews. Even though the interview period might not be long, I realised that the preparation stage was vital to getting the desired

information from the right people. It allowed me to go into my interviews well-informed; something I found placed me in a proper position for the creation of a reciprocal relationship between my informants and myself. On the weak side, the limited period did not permit me to transcribe my interviews immediately after an interview, or go through the notes I had taken while on the field. Being able to do this would have been an advantage to improving my findings. I might have found other issues which could be added to those I had covered in my interview guide, or discovered possible relevant issues for review as I could recall my interviews easily. Nonetheless, my interviews were recorded and so I could do that at a later period.

With regards to the place for my interviews, I had a preference for conducting my interviews in places which presented the least challenges and obstructions. However, I did not relent on giving my informants the benefit of choosing a venue where they would be comfortable and feel relaxed. My interviews with the OSHIS and the health workers took place in their offices. In as much as it was the preference of the interviewees, I realised it was advantageous as the interviewees had access to more information in their offices; documented and online, than they would have should the interview be conducted elsewhere. This gave me access to a lot of information as well. Some of my interviews also took place in informal settings. Some interviewees were chanced upon in their homes and the health centres. Others were interviewed in the streets, public places where they frequent such as game centres (most of these informants were unemployed), community centres (where there was a mass registration exercise), and at work places such as a fishing site in one of the fishing communities.

Even though I tried to minimise space-related problems, some challenges persisted. These included the following: sometimes, there were interruptions in the interviews, especially in the homes. Children made noise and it was quite difficult controlling them while at the same time focusing on the interview. In such situations, I halted the interview and allowed the adult time to keep the children under control. Continuous breaks in the interviews negatively affected the rapport I built with such informants and delayed the interview.

Another problem I encountered was with neighbours. Some neighbours whom I had not talked to were suspicious of my identity. There was the potential of informants mistaking me for a government official; a notion which had the possibility to influence their responses. To avoid getting untrue or exaggerated information, I made explicit my position as a student researcher and the purpose of my study. I realised later that it was also necessary to introduce myself to neighbours of each home or office where I paid a visit instead of only the informants. The

technique proved to be useful, however, it consumed some time. Conducting the interviews in the homes however presented me with the opportunity of observing the informants closely, their living conditions, household assets and the family dynamics, thereby gaining additional observable information. In the offices, I observed the work routine, client-staff relationships and the state of the facilities for work.

In most situations, the timing of my interviews was dependent on the preference of my informants. Since the interviewees in the formal settings had to attend to official duties at regulated times, they often fixed the time for the interviews. Usually break periods and the early hours before they started a day's work were used. Even though the convenience in the timing allowed these informants to prepare adequately before the interview, I encountered a problem of not consistently meeting up with my interviewees at set time schedules owing to the need to attend to emergency meetings and unscheduled job-related demands.

Since the interview was conducted during the rainy season, it rained often and this sometimes delayed our meetings. It was either the informant or I was at the agreed place at an earlier or a later time. I realised that most people were at their work places and not at home during the day; as such I visited the homes in the evenings when they had returned from work. I also conducted some interviews on weekends. Although the timing was suitable, I realised that it was not the most convenient for informants who returned from work in the evening as they could be tired.

The interview relation

Underpinning a successful interview is also careful planning and adoption of the right practices and attitude before, during and after an interview. Impression management for instance can have an effect on the result of an interview. The researcher might acquire untrue or true information based on how he is seen by the interviewee (Hesselberg 2013). If the researcher creates a negative impression, for instance dressing up instead of dressing down, or vice versa, his personality as the one who is usually powerful is enhanced, thereby encouraging the informant to give information which sounds culturally acceptable but not a true reflection of the reality. Bearing this in mind, I set out to achieve a reciprocal or a power-balanced relationship as much as I could. I wore casual clothing where I interviewed in the streets, homes and public places. Where I conducted my interviews in a more formal environment such as the OSHIS and the

district assembly offices, I put on formal clothing. I concluded on which clothing was appropriate for the interviews I conducted with the different categories of people after I had acquainted myself with the cultural context of my potential informants.

In addition, the relationship created between the interviewee and interviewer prior to an interview contributes to how insightful the interview can be. Hay (2010) posits that information obtained through an interview is likely to be more insightful if the interviewee and interviewer are at ease with each other. Hay suggests the use of *warm-up* techniques for establishing the desired interview relationship for a successful interview. My own warm-up techniques were: giving the informants an overview of the questions I intended to ask them, asking them general knowledge questions about health insurance, whether they had any form of insurance, for instance crop insurance or life insurance and how useful they find it. I found out that it activated their mood to talk more about the NHIS, as it embodied the practicalities of most of the things they talked about. To help maintain rapport in my interviews, I used cues to encourage my informants to talk at length. At the same time, I was conscious to listen to them carefully and minimise as much as I could, my influence on the opinions they expressed.

In ending my interviews, I found it was necessary to maintain rapport and a nice relationship through and after the interview, and to create a sense of continuity and of feedback and clarification rather than end with an atmosphere of finality. I did this so that should it become necessary that I again contact a previous informant, I would be granted audience. In closing my interviews, I always asked my informants whether there was any additional information they would like to add to what they had given, probably something we had not talked about.

Question ordering

The ordering of questions is equally important to consider in order to preserving rapport (Hay 2010). Various options exist for ordering questions for interviews. The ordering could have a pyramid structure in which case the interview begins with easy-to-answer questions which pertain to the informant, and then graduate to a more generalised questions. It could also start with general questions and then turns to those which are particular about the informants. Better still, an interviewer could begin with easy-to answer questions, move on to the abstract ones and finally to the sensitive issues. Regardless of which type is chosen, the interview questions should

comprise of primary and secondary questions. The primary questions are used to initiate the interviews whereas the secondary questions are used to encourage informants to expand on issues they talk about. They serve as prompts (Hay 2010).

My questions were a mixture of primary and secondary questions with the secondary questions being nested within the primary ones. I considered the pyramid type of ordering as more appropriate for interviews. My interviews often began with questions which pertained to the particular experiences of the informants, for instance an opening question to uninsured person was why he was uninsured. I realised that this allowed the informants to get accustomed to the interview, while at the same time limiting the need for deeper reflection or thinking at the initial stage of the interview, thereby maintaining rapport. I asked the general questions which required greater reflection on thoughts at the later part of my interviews.

Recording the interviews

Before I started any of my interviews, I asked the interviewee if he would permit me to record our conversations. All my interviews were recorded, except one which the interviewee asked that the recorder was put off since she was uncomfortable with it. I recorded my interviews with a combination of the techniques of audio recording and short note-taking. I chose to use the two techniques to ensure that my interview data were detailed as much as possible by tapping from the benefits each of the techniques offer. For me, recording the interview was necessary to help me capture fully the verbal data, and to focus on the interview as the practice limits mental wandering, it keeps the conversation natural and maintains rapport in an interview (Bryman 2012). Again, I could always have a replay of my interviews and listen to what was said, this I found out would help suggest what changes to make or add to the subsequent interviews. However, I thought also about the limitations of using the audio-recorder and decided to take short notes. The audio-recorder is unable to capture non-verbal data such as observations made about the interviewee or the place of the interview, gestures and body language. In addition, in case of a technical failure the audio-record could be lost. I should say that the note-taking was limited to the non-verbal information in order to avoid the stress of writing too much and to enhance my concentration on the interview.

Ethical considerations

Research work revolves around ethical considerations. From the choice of a research topic, through to making decisions about which method and techniques to use, who to involve in the research and how to relate to participants of the research, ethics should be an issue of concern (Hay 2010, Bryman 2012). Research ethics can be referred to as the conduct of researchers, their duties and responsibilities to the participants of the research such as sponsors, informants and the general public (O'Connell-Davidson and Leyder in Hay 2010). The main ethical issues which are usually addressed in research revolve around *privacy, confidentiality, informed consent, deception and harm* (Matthews and Ross 2010). In the subsequent discussion, I bring out how I addressed these ethical issues in the process of my research.

Informed consent

As stated earlier, prior to the research, I sought the consent of my key informants. This was the initial stage of securing contacts and gaining access. I sought the consent of other informants while on the field. Consent should be informed, and freely given (Matthews and Ross 2010) meaning that it should go beyond the mere acceptance of an informant to take part or refuse to be part of the research. Bearing this in mind, I explained the purpose of my research to all my informants, the issues we would be discussing, what was expected of them, what the information they gave would be used for, and the estimated time required to complete the interview. I also sought the consent of my interviewees before recording any of my interviews.

I introduced my identity as a student to my informants. This I did verbally and with my introduction letters. None of my informants was pressurised or forced to participate. All my informants were given the liberty to opt out of the research whenever they deemed it necessary. Throughout the research process, the focus remained considerably unchanged, that is the objective of finding reasons for non-enrolment into the NHIS, and so the possibility of encountering a problem like deception of informants due to a change in the research focus which would violate ethical principles was non-existent.

Privacy and confidentiality

Researchers might be presented with the dilemmas of ensuring privacy and confidentiality of informants' opinions (Bryman 2012). Qualitative research involves intruding into people's private lives: experiences and opinions which individuals might prefer to keep secret. As such, it is of utmost essence that the researcher keeps safe the informants information, guard its use and does not abuse it. Doing this might not be that easy all the time as the researcher might for instance discover illegal behaviours in the research process, in which situation he may be torn between making such information public or secret (Matthews and Ross 2010).

Similarly, informants in public settings may give useful information which could be beneficial to the research but including such information might reveal the identity of the informant (Bryman 2012). In this sense, giving fictitious names can be useful in making informants anonymous. In ensuring that my informants' identity was not revealed, I did not include the original names of any of them in my transcripts. I should say that it was difficult masking the identity of those key informants who hold public offices. Better still, their names have not been given, thereby giving an assurance of *not-easy-to-reveal* identities. With regards to privacy and confidentiality of informants' information, I kept my field notes, transcripts and recorded data in a safe place where access was restricted.

Protection of informants from harm

Research can cause harm to participants, however, it is particularly difficult to predetermine what sort of harm could be caused, especially in qualitative research (Bryman 2012). Any harm that can be caused is usually not easy to observe but may unfold in the research process. The questions asked in an interview for instance may trigger psychological and emotional trauma among informants. In conducting my interviews, although my interest was to acquire insightful information as far as possible, I was equally watchful *not to hitch* on issues which were likely to be upsetting or potentially psychologically damaging. I tried to also rephrase my questions to give them a refreshing tone whenever I realised that an informant's mood had been adversely affected by a question I asked. I assured informants that they were free to keep any conversation they deemed private outside the interviews.

Rigour of the research

In every research work rigour is an underlying principle. Researchers have a responsibility towards their interpretative communities; subjects, readers and the general public to ensure that the work represents findings which are true but not one based on the researcher's own assumptions (Hay 2010). To ensure rigour in a research work means to ensure trustworthiness of the research (Matthews and Ross 2010). In quantitative studies, the standards set for achieving trustworthiness of a research work can be categorised based on these terms: *generalisability*, *objectivity*, *validity* and *reliability*. These concepts have been adopted into qualitative studies but from different perspectives revolving around the terms *confirmability*, *transferability*, *credibility* and *dependability*.

The argument for the use of these words is that qualitative methods differ significantly from the quantitative methods in the approach and techniques employed. As such, it is difficult to apply these same principles across methods. For instance, objectivity relates to absolute independence of the researcher from the object of study and study participants. This kind of objectivity is difficult to achieve in qualitative studies (Hay 2010). As Hammersley and Atkinson (2007) point out, since qualitative research process involves interaction of the researcher with the study objects, both of which might bring their personal perspective to bear on the research, it is often described as subjective. Of equal significance in ensuring rigour of qualitative research is the issue of inter-subjectivity. This refers to the interpretations and the meanings that researchers give to the language and actions of the study participants in their findings as a result of their interactions with other people they interact with in their study (Hay 2010).

Although the argument put forth might portray qualitative research as one which is distant from eliminating biases, yet still, greater degree of rigour can be achieved, and these are largely based on the researcher's conduct in the research process. Hay (2010) argues that being aware of the possibility of biases, and putting in the appropriate measures to minimise the effect of social relations on the findings of a research is one good strategy for dealing with subjectivity and inter-subjectivity. This also means that the researcher is being critically reflexive.

Dependability of a research refers to how consistent the research process has been, that is, whether the findings of the research are free from biases, or the possible biases and their influence on the research are brought to light so that the interpretative community can appreciate the extent of trustworthiness of the research. Credibility refers to how truthful the research findings are. For instance do the findings give a true reflection of the opinions and experiences

of the people studied? Confirmability refers to the degree to which the same findings can be reproduced within the study context by others when similar techniques are employed. Transferability refers to the degree to which the findings of the research are applicable to a wider population outside the study context. Since qualitative research is context-specific, the issue of the possibility of transferability has been argued over. Although the findings of a case study can be transferred to a wider population (Hay 2010) it is important that the researcher makes explicit the extent of transferability of his findings. In the subsequent paragraphs, I outline how I ensured rigour in my research by incorporating the standards of dependability, credibility, transferability and confirmability.

I should emphasise that achieving fully the laid down standards for trustworthiness in a precise manner in my research could not be assured. However, I tried to near the *precise* as much as possible to ensure that my findings are valid. I employed some measures to ensure that my findings are consistent. I chose my informants in an unbiased manner, mainly guided by the research objective. All informants were asked similar questions as a guide was used for my interviews.

The issue of confirmability of the findings is more delicate as different researchers have different opinions, experiences and these they might bring to bear on the research, in which way the findings might differ considerably. To minimise the impact of this problem on my research, I employed the interview type which allows sufficient flexibility to informants. In this way, their views became more important than mine in the research process. For me, this is a credit for ensuring that my findings are valid as the analysis is based on the perspectives of my informants rather than on my expectations. I also tried to achieve flexibility by keeping a research diary in which I scrutinised myself while conducting my interviews. For instance I asked myself at some points in my interviews whether my perceptions and opinions prior to the research had changed, whether my informants' perception about me was power-laden, or our interactions were constrained by gender or age.

To ensure credibility of my findings, I used secondary questions, most of which required that informants expanded on an answer they gave to a question. In using follow-up questions, my interest was to find out how consistent and truthful the informants were. Though it may be difficult to tell when an informant is telling lies, by combining observation techniques and the use of the follow-up questions, I was able to sense it when an informant was telling lies,

especially when the informant was inconsistent in his expressions and answers to questions. I excluded interview records which had inconsistencies.

I should admit that transferability of the study findings could be difficult to achieve as the information gathered though mostly revealed similarities, there are equally significant differing reasons for non-enrolment in the various study contexts, most of which are dependent on the individual experiences.

Chapter summary

This chapter has discussed the choice of a qualitative method for the research work. I have argued that qualitative method is best suited for my research objective as it offers the benefit of flexibility in interactions and detailed informants' information which might reveal differing opinions or consensus on opinions. However, the flexibility permitted by the method means that there is the possibility that I might have also incorporated my personal biases thereby making the information gathered misleading in a way. I employed critical reflexivity to deal with this problem in my research. I have outlined other shortfalls which have the equal potential of affecting the research findings. These include: my unfamiliarity with the research area and the fact that I was unable to include the remotest parts of the districts. Perhaps they could have revealed quite interesting findings. However, these problems I believe did not alter the research findings significantly as the preparation stage informed me that those areas which were chosen for the study could as well reveal interesting results. Having overcome the challenges identified, I believe that my findings are accurate and reliable.

Chapter five

What explains non-enrolment?

In this chapter, my focus is on seeking answers to the research question of this thesis, that is, what explains non-enrolment in the study areas. I will seek answers to this question by prioritising the presentation and analysis of the opinions of my informants as collected from the field, and also making reference to literature and theory where applicable. Before I proceed, it is important that I give readers an overview of the socio-economic background of my interviewees. In this way, it will be easy to identify them, comprehend the reasons for the opinions they give and the significance of their opinions. Individual rather than household interviews were conducted for the purpose of identifying differing opinions peculiar to the individual uninsured.

Socio-economic background of interviewees

The socio-economic background of my individual interviewees reviewed variations: males and females, below 18 years, between 18 and 70 years, above 70 years, married with and without children, unmarried with children and without children, small scale subsistence farmers, petty traders, an apprentice, a hairdresser and fishermen, unemployed, physically able and physically disabled. A number of the informants were engaged in livelihood activities enhanced by the natural resources found within their geographical locations. For instance the fishmongers and fishermen informants lived in the study towns drained by the Volta River, while some who lived inland near the district capital were involved in retail trade, and farming. All informants fell within one of these ethnic groups: Ewe, Ada and Kwahu and were Muslims and Christians. The purpose for selecting the identified groups was to find out whether their socio-economic characteristics had influence on non-enrolment as reviewed in the literature.

Since some of my interviews took place in the informants' homes, I took the chance to study the outlook of their household. Some of them lived in dilapidated rented compound houses made of mud and bamboo, giving me an indication of their limited material resources. Those unemployed without support were among those who had the least ability to enrol. Those found not to have enrolled included adult males, adult females with children but without husbands, unmarried adults without children, informal workers without a stable source of income, and the unemployed with large number of dependents. Although these categories of people had differing

reasons, one unifying factor was significant: the inability to pay. This was identified as an overriding factor which influenced non-enrolment in the study context.

Below, I present the enrolment procedures of the NHIS, and how it influenced non-enrolment in the scheme. I will explore the research question further by looking at the groups which were not enrolling, the length of reasons for not enrolling, and some problems limiting coverage expansion.

Enrolment procedures

The enrolment procedures into the scheme differed slightly for the categories of the population but the registration fee was the same amount. As at the time of the field work, the processing or registration fee was 4 GHC (2 USD). Payment of this amount was required by all these categories of people: the formal workers, informal sector workers, and children below 18 years, the elderly, and pregnant women. With the exception of indigents and pregnant women, the rest were required to pay a premium. Formal workers had their premiums deducted at source as 2.5% of their SSNIT contributions. All informal sector workers paid a fixed and an instant amount of 14 GHC as premium. Out of this amount, 4 GHC was the registration fee and 10 GHC was the premium. Previously, the premium was charged based on the individual income but had been fixed at the time of the interview, due to the difficulty in estimating individual incomes and the belief that when a flat rate is charged, those with the highest ability to pay will pay for their relatives with the least ability to pay. While prospective members paid instant premiums, few in the rural communities mobilised savings for their initial registration and renewal. This was however not a popular practice.

Prospective members of the scheme registered at the office of the OSHIS. This office was situated at Mpreaso, the district capital of the Kwahu South District. Another option was to register with any of the 62 insurance agents, some of which lived in some of the study communities. After taking a passport photograph, the prospective member was asked to fill a form, make an instant payment of the processing fee or premium and then the membership card was prepared. All membership cards were processed in the OSHIS's office and registration agents sent the details of their clients to the same office for their cards to be processed. When the cards were ready, those who registered at the office went there for collection while those who registered with the agents either went to the office, or to the agents for their cards.

Previously, it took a period of three months before new members received their membership cards. By the scheme's policy, new members were supposed to observe this initial waiting period during which their membership cards were processed and prepared. They could seek health care with insurance only after receiving the membership cards. At the time of the interview however, an improvement had been made. I found out that this waiting period had been reduced to two months although this had not been made public since according to Safo, "the scheme is in a transitional period". A membership chit with equal value as the card was given to the newly registered and it could be used to seek health care until the membership card was ready.

Indigent selection

The scheme previously had this strategy for identifying indigents: Those exempted from premium payment were required to show proof of their indigent status. Children and the elderly were required to present a birth certificate as a proof of age, or a relative to confirm their age. The registration officers were also permitted to physically examine, assess and determine the age of the indigents. Similarly, pregnant women were required to present a certificate of pregnancy signed and endorsed by a health professional. To these requirements, the scheme was in a process of introducing an additional strategy of community targeting for identifying indigents on the basis of the inability to pay. With this, opinion leaders in the communities including chiefs, assembly members and religious leaders were to assist in identifying the indigents by providing documented evidence and appending their signature on the indigents' form. The final procedure involved cross-checking, verification and confirmation.

Even though the policy of the NHIS stresses on free indigent registration, priority had not been given to fishing out indigents within the scheme's jurisdiction. The scheme had the responsibility of generating funds internally to finance its operations even though the premiums collected were paid into the NHIA's coffers. The processing fee of 4 GHC charged was what was meant for supporting the OSHIS's internal financial administration such as payment of its staff. Nti had this to say regarding the initiatives of the scheme for selecting indigents:

"Since the beginning of the scheme about seven years ago, there has not been any attempt to look for indigents and register them as it is not helping the scheme. Assuming we (the scheme) have about 40% of our members as indigents, it will go a long way to affect our revenue generation. We used to get support from the government but it is not regular..., the processing fee is the only funds that our office benefits from".

This indicates a lack of motivation and an interest for consciously looking for indigents. Another reason why indigent search had not received priority was that a higher proportion of the population were engaged in informal employment and their incomes were difficult to estimate, the main reason for fixing a flat rate premium. There seemed to be a generally accepted notion that apart from the elderly and the young who could be registered as indigents upon showing proof of age, poverty was almost an insignificant basis for claiming indigent status. Safo, an insurance staff explained that the difficulties and the cost of looking for indigents on the grounds of their inability to pay was not worth taking, because most of the rural inhabitants within the district who also consisted of the larger portion of the districts' population were in similar jobs and earned similar incomes. He said, "It would be extremely difficult and costly to do that".

Renewal

Membership expired after a year and renewal required similar procedures as the initial registration. Similarly, membership under indigent status expired after a period of one year and was subject to renewal. All renewals required filling a form, the purpose of which was to cross-check to find out any changes in an aspect of the previous information given by the member. After this had been done, a sticker was fixed on the card to indicate that the card had been renewed. This was done on the same day of renewal. Previously when the scheme operated as a mutual scheme without affiliation to the NHIS, it took quite a longer period before renewed cards were obtained. The waiting period for defaulters of renewal had also been reduced to two months

Convenience of registration

In order to get a glimpse of the situation for prospective members and registration officers, and to get a better understanding of how it influenced non-enrolment, I observed a daily routine of the process of the registration in the OSHIS's office. The scheme operated in a three-room detached building. One of these rooms was used for registration and the other two for official purposes. This room could accommodate about fifteen people. As a result, a bench had been placed outside the office for any client who turned in at a time when the office was fully occupied. This area had no shade, thereby exposing waiters to the scorching sun, and an experience of discomfort.

While two registration officers took the personal details of the prospective members, one officer entered their data. Occasionally, internet problems were encountered, bringing the registration to a halt. When this happened, I saw frustration on the faces of those in the registration queue. There was one computer which was used for entering registration data and for recording information about service providers who turned in at the office frequently to present their claims forms. Whenever they turned in, the same registration staff attended to them, further prolonging the waiting period for the prospective members.

How do these procedures and requirements influence enrolment?

The first of these procedures I will like to discuss is the rate of premium and the mode of payment. For a significant number of the informants, the premium rate represented the major challenge to their ability to enrol. Although the rate of 14 GHC had remained fixed for the past seven years the scheme started to operate, the difficulty in paying persisted. Making reference to the consumer theory (Lancaster 1966) a change in price has a potential to influence the demand for health insurance. In the context of the study, an informant was uninsured not because her decisions had been influenced by a change in the price of the insurance, but that her income had not appreciated to improve her ability to pay. Serwaa, an unemployed and a divorcee mother of three pointed out that if she found someone who was willing to pay for her, then she would enrol since she could not afford the premium.

Additionally, it was evident that the belief in family solidarity and support from the family system had not played an effective role to help members raise the amount for premium payment. In contrast with the findings of Jowett (2003), support from relatives was vital for enrolment in the study context. Non-enrolment could be attributed to the scarcity of financial aid, and even when it was received the beneficiary was required to pay back. Vida, a petty trader and a mother of three explained that she had not enrolled because although she had been able to raise part of the amount required, it had been difficult to get the remainder from any of her relatives she contacted. She lamented:

"You know what; relatives prefer to lend to non-relatives when they have money because they get interest. They think that when you give your money to your family member, she might not pay back and there is little you can do about that for the sake of your family relationship".

In contrast, Rose, an apprentice and a mother, found the modality of premium payment to be rather the major difficulty. If instalment payments were introduced into all communities and entrusted into the hands of competent and trustworthy agents, it could probably ease the difficulty concerning premium payments. She explained that she could afford to pay if the agents accepted payments in bits. She could afford at least 10% of the premium each month, implying that by the time her insurance expired she would have accumulated enough for renewal. Besides, she found the amount for renewal to be rather expensive and expressed that if someone was renewing, the amount should be cheaper than the initial premium.

Bright, a 14 year primary student had not enrolled. He had three siblings who were all under age 18. According to him, his father had registered only his two younger siblings because he did not have money to pay for all four of them at a go. The registration fee for four kids exceeds the premium for an adult, and this is as significant as the premium charged. Normally, parents should pay the processing fee for their kids. This implies that parents who have difficulties paying premium might also not be able to pay the processing fee to enrol their kids, especially when they have many dependents and unstable or no source of income.

The case of Sika further exemplifies this finding. He had 18 children and three wives. When asked about his opinion regarding the rate of the premium he commented:

"It is ok but those of us who have many children it is difficult. You know the nature of our work. It is seasonal and so during the off-seasons money becomes scarce".

This interviewee had income at irregular periods which made it difficult for him to enrol or renew his children's membership or his own at a period their membership expired. He recounted that he managed to register five of his children but their membership expired and he defaulted renewal before he could raise money to register for the rest of his children. This also brings out the issue of timing in relation to premium payment. If waiting periods were not imposed, and membership expiration could be extended when people had the means to pay, then the influence of timing of premium payment on the ability to pay would be minimal. The finding is consistent with the discovery of Atim and Sock (2000) in their study which noted that low enrolment was because registrations took place during the months when coverage income of the population was lowest. It is also in line with that of Chankova et al. (2008) which showed that yearly payment schedule is unsuitable for low income earners.

While children are dependents, the elderly on pension are also in most cases dependents and encounter similar barriers to enrolment. Nyarko, a 67 year old woman lived with her married daughter and was not insured. She depended solely on her daughter's income for her livelihood and her daughter's trade had not been profitable for some time. She was waiting for events to take a good turn so that her daughter would pay the premium for her. The retired age in Ghana is 60 years, suggesting that those above this age are not productive economic wise, yet those between age 60 and 70 were excluded from the indigent premium exemption policy. Obviously, this age categorisation is not fair enough because beside the fact that many of those who had retired could not work, those who retired from formal work paid only registration fee although they received pension benefits, while the retired from informal work not entitled to pension benefits paid premium.

This reinforces inequalities in health care accessibility as those who retired from informal jobs were at a more disadvantaged position to enrol, and that premium and processing fee were both barriers to enrolment. If coverage can be increased through indigent enrolment, then there is the need to make registration free not in relative but in absolute terms for those in the indigent category and those on pension.

Another way registration influenced non-enrolment derived from the declining trust in agents and the location of the OSHIS's office which I identified to be a comparatively preferred registration point. Adelakope, a 28 year old farmer was uninsured. He complained that there used to be an agent but he made away with their contributions and he had not seen him again since then. For this reason, he preferred to register at the OSHIS's office rather than with agents. Meanwhile, the transportation fare to the office almost equalled the cost of the insurance premium, thereby increasing the actual cost of enrolment for this informant. He was willing to register if the OSHIS's registration team itself showed up at Kotoso where he resided.

While Adelakope had lost trust in an insurance agent, Bempa, a farmer was unaware of an agent in his town of residence. Although the OSHIS claimed that the 62 agents they worked with were living in all the communities within the district, I realised that there was no formal process for introducing these agents to the residents in the communities within the study context. According to Safo, agents were paid on commission basis and their task was to register people into the scheme. "The OSHIS cannot afford to provide offices, publicity or identity cards for them", he said. The only way they could make themselves known as agents was by entering people's homes and convincing those who they were lucky enough to meet to enrol. This indicates that

the lack of awareness about the existence of insurance agents and where to find them had influenced non-enrolment.

Another element which in the view of the OSHIS was aimed at increasing coverage but which I found falling short of its objective was the timing of mass registrations. This exercise mostly took place at inconvenient periods of time, thereby limiting patronage. The OSHIS organised mass registration in some of the communities occasionally. Announcements were made prior to the registration dates but within short period intervals, and there were no fixed durations for such exercises. Owing to this, Kudjovi a fisherman and a potential enrollee often missed out. He had this to say about why he was uninsured:

"The nature of my job is such that I am not stationed at a particular place and whenever the insurance people are around to register people I miss them".

This implies that mass registrations were organised without considering how convenient the timing was for the intended population. Farmers in the study communities usually went to their farms in the mornings and returned in the evenings around 3:00 pm. Fishermen worked during favourable seasons. The common day one could meet most people in their homes was on the weekends. Some farmers trading their products, fishmongers, truck pushers, and street vendors could also be easily found in the market during the market days. Fixing the registration dates on market days could be helpful but within hours when people were engaging in their income generating activities resulted in low patronage. This is because some people could simply not sacrifice their time for making money to register. Again, if people are unaware of the dates for registration or receive information shortly prior to the set period, a number of potential enrollees might not have accumulated enough money to register for themselves or their dependents.

The requirements of the indigent selection process posed a number of limitations to those who could benefit from the policy, and these were made evident by informants who in my view qualified as indigents. As per the policy, those who had no identifiable source of income, residence and did not receive support from a person with an identifiable source of income qualified as indigents. It was revealed that some groups who had similar conditions and difficulties in their ability to pay just like indigents were excluded from benefiting from the policy. A typical example was the physically challenged. They had no benefits under the indigent policy.

An exemplary case is that of Coby who was an amputee and an apprentice. Although he was 25 and was not recognised as a dependent, he was unemployed and virtually living on the support

of his master who was also married with children. He lived in a mud house whose roof leaked and had almost been ripped off. For me, he passed as an indigent due to his health status and economic condition, yet he had not registered because per the NHIS's policy, he was not one. People with disabilities depended on their own financial resources, or counted on the support of others in order to insure. The implication is that if they were unable to raise enough money or get help from others, they did not enrol.

Similarly, Poku had been unemployed for more than three years and his wife who was a trader had been providing money for the upkeep of his family. Poku did not qualify as an indigent but his wife had not had enough money to register for him and their three children, and so he remained uninsured. Two of these children were above 18 years but were unemployed and living with the parents, implying that they had to pay premium. Reviewing Poku's situation, he fell into a precarious group more than one considered as an indigent. Being a dependent with dependents, he had to make compromise on his own health. He considered his children as being more vulnerable than he was and so if there was insufficient money for registering his entire family, his children had to register before he did.

On the other hand, Kuma's age qualified him as an indigent but he was uninsured because he could not proof his age. He said:

"I don't have a birth certificate to show that I am over 70 years, and I am not prepared for the stress involved in obtaining one. If I want to get a birth certificate, I have to go to the district capital several times after paying money for everything".

This informant looked quite fit and one might assume that he was below 70 years. He could work and had shortly retired from his cocoa farming. This means that he was not likely to be granted indigent status through physical examination though he qualified as one. Sika also faced this particular problem in his attempt to register 7 of his 18 children. The agents refused to register them because they failed the physical test for indigents. Their birth certificates were missing and he felt that making new ones for them was expensive and unworthy since it cost more than the registration fee.

Similarly, Rose qualified as an indigent because she was pregnant but she could show no proof of her pregnancy. Pregnancy test could not be done at the only clinic at Nkyenenkene, the town where she resided, and the cost of a test plus a return trip to the nearest health centre would cost her more than the premium. She felt discouraged to do so.

The cases above reveal shortcomings of the indigent policy and the registration requirements which adversely influenced enrolment. While the physically challenged and the unemployed have been excluded from the category of indigents, they also find it difficult to pay premium. Physical examination of indigents is inappropriate and discriminatory as it eliminates some indigents. On the other hand, the age categorization of indigents is bias in the sense that a significant number of those outside the indigent age category have insufficient or no source of income. The unemployed with dependents face the pressure of the need to register their dependents and themselves. Agents particularly have little enthusiasm to register indigents since they make financial accounts to the OSHIS and are paid on commission basis. While the registration fee for indigents might be regarded as a meagre amount to encourage enrolment, the realities of the difficulties in providing the requirements for indigent status recognition eliminate a significant number of indigents. Besides, education about the policy has not been widely carried out and so majority seem not to be aware of it.

In as much as prospective enrolees had the confidence in registering at the OSHIS's office than with some agents, it was evident that the inadequate space and internet problems which were frequently experienced affected the speed of work at the office. According to Safo, "there were days when the internet could not be accessed". Whenever this happened, they took the details of the clients but could not work on it until the internet access was restored. Due to this, they had a backlog of data on prospective enrolees which was yet to be processed.

In another case, the problem outlined above did not only affect the speed of work at the insurance office but also reduced the enthusiasm an informant had for becoming a member of the scheme. Rose had been to the office with her daughter who was in primary school on two occasions in order to register her. On each of their visit, they waited in a queue for more than an hour without being attended to. She had to attend to her goods which she sold in another town and she did not want her daughter to miss school the third time, so she decided she would register when she had enough time at her disposal. It can be inferred that a significant number of those who experience similar inconveniences will not be motivated to enrol.

Which groups are not enrolling?

In this section, I group the informants all of whom were uninsured into categories. This grouping has been done, making reference to the socio-economic information of my informants.

My interest is not to attempt a generalisation with this information since the informants do not make a representative sample. However, I believe that the grouping gives an overview of the common characterisation of the uninsured within the study context.

Age

Non-enrolment was not confined to a distinct age group as my uninsured informants spread across the indigent and non indigent age groups. However, on the average my uninsured informants belonged outside the category of the indigent group, thus between age 18 and 70. This non indigent group can be referred to as the *active population* since they engaged in productive work. Although this finding is expected since this group pay premium, it is also interesting because being productive means they have the higher ability to pay. In correspondence to the literature (NHIS 2012) the NHIS indigent policy is seen to have influenced the age trend of non-enrolment in the study context.

In a number of cases, the active population prioritised paying the registration fee for their dependents rather than paying their own premium. This finding is consistent with the observation by Lemay-Boucher (2007) that higher number of dependents suggests a greater possibility of adverse health effects. The contrast here is that this condition did not translate into a higher demand for health insurance as found by Lemay-Boucher. In this context, dependency increased financial responsibilities and limited the ability to pay and enrol.

Gender and the decision to enrol

Free health care for pregnant women and the perceived higher vulnerability of women was expected to produce a gender bias effect on enrolment, by reducing non-enrolment among females as shown by Buor (2003). Asante confirmed that "more females than males seek health care with insurance because the men think that they are stronger". Moreover, a review of some informants' opinions on vulnerability and risk had an additional significant influence. In each of the cases below, the need to prioritise the enrolment of women and children was evident, and of the need to put the health concern of dependents first.

Ofori had insured his wife but he was not insured. He said, "I seldom fall sick but my wife has high blood pressure and goes for check-up every two weeks so I registered for her". Ahiatroga

had registered his three wives who were unemployed because he explained that they could fall sick more often. Boja had registered one of his children but not he because he perceived it would be a waste of money since he did not fall sick often. "You know children often fall sick", he said.

Normally in the traditional Ghanaian society, the men head their household, implying that they have control over the family's resources. It is expected that they will appropriate the resources putting their interest first, thereby enrolling. The above cases indicate that men did not always put themselves first in appropriating resources for health care. Besides, they felt they were less vulnerable to sicknesses than children and women. Consequently, they insured their children and wives and if there was an adequate financial resource they insured. This finding is consistent with the expected utility and prospect theories. It is evident that in deciding on who enrolls with the limited resources, health risk vulnerability played an important role. Those perceived to be highly vulnerable to ill health and thus required much health care received higher consideration.

Healthy groups

In addition, there is an evidence of adverse selection, implying the preference to register when vulnerability is high. The absence of dependents further reduced risks. A statement by Kujovi throws more light on this finding. "I have no wife and children and I do not get sick often. I therefore do not feel the urgency to enrol", he said. He explained that since he had no dependents it was not too necessary to think about how to deal with the cost of health care. He could manage to take care of himself when sick. This statement reveals that while dependency can limit the ability to pay premium, the absence of it also reinforces a feeling of the *needless to enrol*, especially when there is a perception of being healthy. Besides the perception that one who has no dependents might have less frequencies of vulnerability and health risk to deal with, being healthy might lower the prospects healthy groups derive from enrolment. This finding corresponds to the expected utility and prospect theories which stress that risk aversion and the need to make gains from insurance influence enrolment.

Females with dependents

Reviewing the cases below, it becomes evident that the difficulty to enrol is even peculiar when a person is independent with dependents. A typical group evident in the study is women who are

unemployed, have children and live without their male partners or do not receive adequate support from them. Dela's husband worked as a labourer on a cocoa farm in a nearby village. He did not send money home often, and Dela was struggling to feed her children with the little money she made irregularly from the sale of their farm produce. She could not afford to pay premium. Serwaa's husband was cohabiting with another woman whom he had impregnated. She had to take care of their children single handed, meanwhile she was unemployed. In contrast, Selasi lived with her husband but the husband was unemployed. These cases indicate that *de jure* and *de facto* women who are independent with dependents might face credit constraints, limiting their ability to enrol, while financial support and additional income from males can have a significant effect on the ability of women to enrol.

Informal workers with unstable income

Reiterating safo's words:

"The majority of the population are low income earners and their incomes are difficult to estimate. More importantly, these informal workers are engaged in primary activities: farming and fishing, and their non-enrolment have been influenced by the seasonal nature of their work which results in a lack of regular incomes".

Referring to the appendix 1 and the literature, this information holds true. The occupational trend of my informants affirms the importance and commonality of primary occupation in the study. Farming, fishing and trading were important sectors of employment for informal sector workers in the study. Since this group often receives low incomes at irregular periods, Vistnes and Monheit (2006) point out that they have a greater likelihood to enrol in order to secure against risk and catastrophic health expenditure. This study however does not provide any evidence to support higher enrolment among informal sector groups. A reason might be that the low and irregular incomes received do not necessarily translate into risk aversion, or that the aversion for risk does not carry enough weight to discourage satisfying basic consumption needs and thus propel enrolment, as it has been made explicit by the poverty literature. It must also be noted that the willingness to pay differs from the ability to pay in this study. For instance, Rose was willing to enrol but had not the means.

Basic school leavers

The educational qualification of the uninsured was another interesting finding. Monheit and Vistnes (2006) and Mathauer et al. (2008) draw attention to its influence on enrolment, pointing out that it enhances the understanding of an insurance scheme rationale and promotes enrolment. This study does not lend support to this finding as revealed in the cases of Rose and Adelakope who were basic school leavers. Even though these informants had not attained higher levels of formal education, they demonstrated having a clear understanding of the insurance scheme rationale and the procedures for registrations. Their non-enrolment was clearly had no significant relationship with their educational attainment.

The most important identifiable significance of education on enrolment in the study context was its relationship with occupation. These informants were engaged in jobs which required less educational qualification. Farming, trading and fishing were common jobs for the least educated. The necessary requirement was the initial start-up capital. It is important to point out that these jobs were among the least paid, and had a bearing on their income levels which influenced the cash constraints they faced, limiting their ability to enrol.

Religious beliefs

The influence of religiosity on enrolment sheds light on risk perception as discussed in the literature (De Allegri et al 2006b). A group of Christians had been influenced through doctrines to hold a belief that it was not right to pay for security towards the cost of future health care as it implied a disbelief in the protective power of God. It is inadequate to generalise that the religion itself influenced non-enrolment since the informants whose opinions revealed this did not attribute their status to their religion per se. Besides, the population of the study areas were predominantly Christians with few Muslims and traditionalists. However, it is important to stress that within the Christian Religion, non-enrolment had been influenced by the beliefs of a religious sect called the *gyidi kokoo*, literally translated as *the red faith*. According to Safo, they had continually recorded lower rates of enrolment from the towns where *gyidi kokoo* had large membership. For Ago who belonged to this sect, "insuring is like buying diseases". Dela a member of this sect also expressed:

"If you do not have faith that God's protection exists, that is when you insure. God did not create diseases for humankind, it is the devil who sends sicknesses and if I pray ceaselessly, God is able to protect me and my family from sicknesses".

Intuitively, the belief of this religious sect has an influence on the perception of risk and disease causation of its members. They had a conviction that anticipating poor health contravened their beliefs, and this affected non-enrolment among them. The use of spiritual healing was identified to be profound among the members of this religious sect.

Although Vida belonged outside this sect, she also attributed disease causation to natural and spiritual events, and had a dual health-seeking behaviour: usage of formal health care and self-medication. For her, she was uninsured not due to the influence from religious beliefs per se, but a reflection of her inability to pay since she sought health care in the health centres when she could afford to pay at point of service.

Why are they uninsured?

While the groups identified as uninsured expressed some common reasons for their status as elaborated, a significant number of differing reasons which were influenced by some peculiar problems reflecting the socio-economic situations of their geographical locations were also identified. In this section, I explore further the reasons for non-enrolment in the study context. It is important to stress that while informants expressed their belief in the financial protection effect of the NHIS and their willingness to enrol, a number of reasons influenced their status. Some of these reasons related to the uninsured, others were external and originated from the providers of health care, the insurers and the play of politics. In respect of this, the thesis studies the influential factors of non-enrolment from the perspective of the insurers, service providers and the uninsured. The reasons have not been discussed in an order of severity, although some carried more weight and influence than others. In view of this, I conclude this section bringing out the *necessary* or more *important factors* as against the less important ones.

Ability to pay

While Coby, Kwaku, Asibi, Bempa and Ago expressed that the premium was *fair*, they also admitted that they found it difficult to raise the amount. Other reasons given by the informants can be placed as supportive while the inability to pay assumed a leading position. For instance, Vida too was waiting to get money, and then she will insure. Rose was previously insured but dropped out because she could not raise the entire premium before her membership expired, and

Serwaa had not saved enough to pay for premium. This finding bears similarity with a number of studies in Ghana including those by Jehu-Appiah et al. (2011a) and Sulzbach et al. (2005) in which the inability to pay premium represented the greatest challenge to enrolment.

Inferring from the poverty literature, individuals with the least incomes are more risk-averse and might sacrifice current consumption in order to secure themselves against future loss of income which will push them further below the survival line. In this study, these informants are perceived to have the least incomes, yet they showed a limited aversion for risk. How this was made obvious? It is interesting to find that the need to insure was not prioritised over the need to satisfy food needs of the individuals and their dependants as posited by Monheit and Vistnes (2006).

While Bempa thought that it was wise to satisfy food and shelter needs first to maintain good health, Serwaa expressed that "it is an act of selfishness to put money aside for health care when one can barely feed herself and family". More pressing needs identified included food, shelter, and catering for dependents. This finding is supported by Serwaa's statement that although she was in a position to borrow money for health care when she could not afford to pay at point of service, she was unwilling to borrow in order to pay the premium.

Besides, the challenge of credit constraints could be explained further by the difficulty to access credit. These informants were not in good standing to obtain loans from the credit institutions such as savings groups and the banks. One reason was their nature of jobs: Comparatively, formal sector workers could easily obtain loans because they received salaries on monthly basis and their incomes could be assessed. On the contrary, these informants could not show documentation as a proof of their income source, the level of their periodic incomes, or their ability to repay with interest. Although family relatives could provide financial help in an acute situation such as in the event of hospitalisation, reiterating Vida's words: "it is quiet rare to receive the support for premium payment, especially when one is physically fit".

Additionally, informants were employed in jobs which did not generate regular incomes. They neither belonged to occupational groups which could seek credit on the basis of their collective credit worthiness, nor worked on large scales to improve their revenue generation or eligibility for government support. In correspondence with the study by De Bock and Gelade (2012) the problem of the inability to pay premium was intensified by the difficulty to obtain credit or subsidies.

Rose and Ofori revealed their preference for instalment payments. A complement which was put forward by Ofori who saw fairness in the premium charged was that it could be affordable if prospective members could pay in bits. He expressed the difficulty in raising the premium and paying all at once. This finding corresponds to that of De Allegri et al. (2006b). Meanwhile, it was difficult to introduce this mode of payment due to the lack of trust in collectors, and the perceived adverse effect it will have on administrative cost.

Risk perception

Having discussed that a limited aversion for risk was identified, it should be emphasised that non-enrolment was also influenced by the degree of aversion as the expected utility theory suggests, and the weights which informants assigned to risks. Although the looming uncertainties of future health risks were known, it was found that these risks had been underweighted. The perceived health status of informants downplayed any feeling of urgency to purchase insurance, and this had influenced them not to enrol. A case on point is exemplified by Kwaku. He had gone to a health centre to seek health care at the time he was interviewed.

"The last time I felt sick was somewhere in 2012, It was a slight headache and stomach pains. Even with this I often bought medicine from the chemical shop and I got well. The first time I registered I never went to the hospital. One of my siblings also registered and never felt sick so it is not so necessary for me to register", he said.

Through an informal chat with the pharmacist at the centre, I discovered that he had stomach ulcer but was unaware. The state-dependent and prospect theories related well to several cases. An assessment of the individual health risk was of essence in the decision to enrol. Kwaku's perceived health status had rather reduced his aversion for risk, expected gains and influenced his decision. He might have considered using insurance if he knew he had developed a sickness which required regular health care. The cumulative prospect theory reveals how underweighted risk further reduces insurance uptake. In Kwaku's case, the experience of headache and pains had been underweighted, implying that they were not regarded as serious ailments which could cause financial lose even without health insurance. For him, these ailments were normal and could be *managed* at a lower cost by individuals. He assigned greater weights to chronic ailments such as cancer and hypertension which required regular medical attention.

Ago shared Kwaku's belief: She had not insured because she perceived herself as healthy, her definition of a healthy person being one who rarely falls sick, or experiences *mild* symptoms

within longer period intervals and does not feel the urgency to visit the hospital on frequent basis. She complained that the unhealthy who enrol benefit at the expense of those who rarely fall sick or visit the health centres. The need to maximise gains from membership, an underlying principle of the prospect and state-dependent theories becomes evident in this case. The above cases again reveal the *preference for reciprocity* rather than for solidarity among the informants.

In the literature (Jehu-Appiah et al. 2011a) we find that individuals' beliefs about disease causation might affect their decisions to enrol. In this study, it was interesting to find that the opinions shared on diseases causation had dual facets. While Ahiatroga attributed scientific explanations to diseases, Kuma believed diseases were caused by evil spirits and offended neighbours. As mentioned earlier, Dela had not enrolled because of her strong belief that God offered protection against diseases. For Kuma and Dela, prayers could prevent illness. The study reveals an association between non-enrolment, risk perception and the perception about disease causation. Particularly, the belief that diseases are caused by spiritual forces was identified to have an adverse effect on enrolment while the belief in scientific explanations to disease causation had a positive effect on enrolment.

Multiple health-seeking behaviours

Closely significant was the health-seeking behaviour of the informants. The emphasis here was to find out the existing alternatives for health care by the informants and how they influenced their status. It is illuminating to find that informants who commended formal health care also revealed optimism about the potency of traditional herbal medicine and spiritual healing, and thus they had multiple health-seeking behaviours. Relating to the status quo theory, it can be inferred that an old practice of using informal health care had influenced the limited insurance uptake in the study. The fact that informal health care had stayed for long meant that it had gained trust, and reduced the urgency for demanding health insurance.

Sika expressed distrust in traditional herbal medicine made locally, but was content with one bought from a chemical shop. His preference was backed by the reason that it was prepared under hygienic conditions. For serwaa, "malaria can best be cured with the leaves of a *Nim tree*". Vida's mother had knowledge in the preparation of traditional medicine for pregnant women. She narrated how her mother's medicine helped to cure her of some complications she experienced after childbirth.

Ahiatroga had become used to seeking prayers for the treatment of chronic diseases and was convinced that it was effective. Although he agreed that formal health care was useful, he did not refute the potency of traditional herbal medicine either. Arguing from a biblical stand point, he explained that God commands mankind to eat the fruit of the earth and use the leaves to cure diseases. Beside the use of traditional medicine, he expressed satisfaction with reliance on drug purchase from the chemical shops in the event of illness.

While trust and potency encouraged the use of herbal medicine, the influence of cost consideration could also not be overruled. Herbal medicine was comparatively cheaper and easily accessible and the statements above reveal that informants either had knowledge on how to prepare it, or had friends or relatives who could do it, or bought it at cheaper prices. In the decision to not enrol, informants evaluated the cost of making point of service payment and the use of herbal medicine or self-medication. The need to cut down on the cost of health care was significant. Dela's case presents an example.

"When I fall sick, I first prepare herbal medicine or buy drugs from the chemical shop. If I get well by the grace of God, then I do not go to the clinic any more. I buy drugs for my children too when they fall sick. Some people take the least pains they experience to the hospital, but it is not every little illness that you (people) should take to the hospital to disturb doctors", she said.

It can be inferred from the statement above that seeking cheaper alternatives to health care was a prior consideration among the uninsured during the early stages of illness. Often the need to go to the hospital becomes pertinent when conditions do not improve, or after self-medication has proven futile over a period of time. In essence, the existence of multiple health-seeking options which were perceived to be much affordable and readily accessible compared to formal health care had influenced non-enrolment in the study sites. This finding is also consistent with the prospect and expected utility theories.

In Dela's case, she did not express reluctance in accepting insurance or using formal health care. Therefore, it is inconsiderate to argue that her status could be explained by the desire to *stick* to the status quo as made explicit in the status quo bias and endowment effect theories, but the concerns over prospects had a greater influence. The consumer theory, status-quo bias theory and Jowett (2003) identified the existence of alternative schemes to have undesirable effects on client choice and a decision to use health insurance. In contrast, the study situation cannot be explained on this ground. There were no private, mutual or commercial schemes besides the NHIS in the study sites at the time of the interviews. Additionally, informants had neither joined

nor benefited from a risk-sharing group. Clearly then, the absence of alternative schemes and informal safety nets had not encouraged enrolment. This indicates further a potential new area for research on coping with health risk in the study areas.

Access to information

Empirical evidence from Kenya and Tanzania (Kamouzora and Gilson 2006, Mathauer et al. 2008) has revealed that lack of information on health insurance and registration procedures have detrimental effects on enrolment. This factor had some extent of significance in the study context but unrelated to enrolment procedures. Bempa was unaware of the agent in his town, yet he knew that registration could be done in the insurance office. The informants gave details of the procedures for registration and renewals. They knew when membership expired, the amount for premium and where to register, an indication that they had enough information to assist them enrol if they had the means.

Another finding worth noting is that contrary to the situations in Kenya and Tanzania, there was an insufficient positive correlation between the educational attainments of the uninsured and their access to information. Kujovi did not know the amount charged as premium, but knew that the scheme had been operational for some time. Kumi and Adelakope demonstrated having a fair understanding of the insurance scheme rationale, pointing out mainly its ability to offer financial protection against catastrophic health expenditure as a benefit. This can be attributed to the fact that the scheme had operated for more than a decade within the district. Through informal education, peer influence, dawn broadcasting, church campaigns and sensitization programmes at community durbars, the OSHIS had made progress in educating the population about the NHIS.

Notwithstanding these successes, there were informants who were not abreast with the changes and improvements which had been made so far in the scheme. The mobility of the scheme was one of these issues. Boja had been discouraged to enrol believing that the usage of the membership card was still limited. When the scheme operated as a mutual, membership cards could not be used to access health care outside the Kwahu South District. At the time of the interview however, membership card could be used nationwide since the scheme had become a national one.

More important in the study was the lack of adequate information about the indigent scheme and the requirements for registration. Selasi was pregnant but was not aware of the free health care for pregnant women. She thought that this benefit was no more in existence since it was introduced during the previous government's administration. She said, "Often policies change when governments are changed". Serwaa knew about premium exemption for children and the elderly people but was unaware that those outside these categories could qualify as indigents on the basis of poverty provided they could show proof. Due to this, it was difficult for her to comment on fairness of the age categorisation and the ability to pay for indigent status recognition. Being an amputee without a recognisable source of income, Coby could consider applying for an indigent status, yet he did not raise concerns over eligibility, an indication of the scanty information he had about this policy.

In an interview with a registration officer, he revealed that the government was considering amending the Insurance Act 650 to include the disabled in the exemption category. The office had received a directive from the NHIA to register a given percentage of indigents. Meanwhile, it was evident that this policy was not going to be made public or enforced any sooner so far as the district schemes had the responsibility to manage their internal financial affairs by increasing internal revenue mobilisation, and additional external support was not forthcoming.

Changes had been made in the waiting period for prospective new members and defaulters of renewal payments. As mentioned earlier, it had been reduced to two months. Meanwhile, there were informants who were unaware of this development and voiced out their dissatisfaction with the previous waiting time of three months. It was revealed that their knowledge about the delays in obtaining renewed cards which were previously a challenge of the scheme continued to influence non-enrolment. Rose said, "I thought it took a period of three months to obtain renewed cards". Although the scheme had become more efficient and issued renewed cards instantly on the same day of renewal, it seemed that this new development had also not received enough publicity.

Selasi had been misinformed about the value of the chit. She commented that she had been told that the instant chit was not recognised by service providers, and that the card with a photo identity was what could be used in seeking health care. This gives an insight into the extent of peer influence on non-enrolment. It is evident that in the situation where the population is not made aware of new developments in the scheme features through formal education, they are likely to be influenced by false information they receive from peers.

Quality perceptions

In a study by Jehu-Appiah (2011a) perceptions of household in Ghana about the NHIS and health service quality was found to have influenced non-enrolment. The perceptions related to convenience of membership, benefit package and the rate of premium. In this study, informants who showed dissatisfaction with the scheme linked it to the fewer gains and the convenience of membership but not the rate of premium. As discussed earlier, fairness of the premium rate had been expressed. It is informative to point out how an informant expressed satisfaction with the procedures for obtaining health care for insurance users and the uninsured. No issue of preferential treatment in seeking medical attention was raised. Ofori's statement throws more light on this:

"It is first come, first serve. We all follow the queue and when it is your turn you consult the doctor. The only difference is that we (uninsured) pay and they do not make direct payment", he said.

Non-enrolment had been influenced by the perceived fewer gains offered by the scheme. Vida had been convinced to hold this perception through acquaintances. She had relocated from Accra and was now considering becoming a member of the scheme because she "paid a lot of money" when she had a miscarriage some time past. Before then, she had decided never to join the scheme. She lamented how her friends who were previous members complained that sometimes they had to pay at point of service before they received medical care, especially when health workers went on strike. For her, there was no need to join the scheme if the membership card would not be recognised throughout its validity period. Vida's case makes valid the underpinnings of the regret and disappointment theory. The past experience without insurance had instilled the regret of being uninsured in her, yet the perception of a possible disappointment with insurance led to her holding back the decision to insure.

Boja was previously a member who shared his bitter experience with the scheme. He recounted how some expensive drugs were prescribed for him to buy when he used to be a member of the scheme. This led him to perceive that the scheme did not offer the complete package which the clients were entitled to. Similarly, Boja's disappointment with the insurance benefit received had influenced his status.

"I don't like the fact that the insurance does not cover some drugs which are necessary to cure the patient. The doctors always prescribe the most effective and expensive drugs for the insurance members to buy. You know this was done to me on two occasions when I used to be a member of the NHIS", he said.

Being a health worker, Asante confirmed the reality of this issue, admitting that it was a challenge which the service providers encountered occasionally. He expressed that it was not done on purpose but that whenever their regional medical stores ran out of supplies, the only option was to prescribe the drugs for the patients to buy. Moreover, he showed how important it was that providers adhered strictly to using the drug prescription lists given by the insurers. If they violated, they faced the consequence of not receiving reimbursement covering the entire claim they made.

The concern here is that although copayments was not an explicit feature of the NHIS, the insurance members who became victims of this problem did not get reimbursement for the extra cost incurred which was a disincentive to enrolment. Besides, victims did not receive any convincing explanation for their loss whenever medication was prescribed. Meanwhile, the content of the drug list was known by the scheme officials and the service providers but not clients. It is only expected that dissatisfied clients will lose the enthusiasm to renew their membership or utilise its usage.

In the words of Safo: "the benefit package is comprehensive" since it covers more than 95% of the common ailment and disease burden of the population. However, the target population for increasing coverage was kept in the dark, having scanty knowledge about the benefit package they were entitled to. It can be analysed that it was only natural that clients will not be satisfied with the medication they received with insurance so far as the extent and the value of the benefit package was not known, particularly if they were given inexpensive drugs or that their sicknesses persisted after using these drugs.

Bearing similarity with Dalinjong and Laar (2012) of significance to enrolment was the attitude of health workers towards patients. As pointed out already, Ofori admitted fairness in the health procedures for insurance users and the uninsured. Notwithstanding this merit, Kwaku who resided in Nkyenenkyene revealed a peculiar problem concerning health workers' behaviour which had influenced his uninsured status. A senior nurse at the only clinic in this town was reportedly rude to patients (both insurance users and those uninsured) who sought health care. She often insulted patients and turned them away if they reported degenerated ailments. The OSHIS admitted getting a wind of this case. At the time of the interview, the case was yet to be looked into by the Ghana Health Service. According to the informant, this situation was well known by the residents of the town and it had resulted in most of them seeking health care from clinics in the nearby towns.

Although this issue was not necessarily a discriminatory act against insurance users per se, it had discouraged Kwaku from enrolling because he was unwilling to bear the extra cost of transportation required to seek health care from other clinics. He preferred to either use herbal medicine or buy drugs in the event of illness.

Trust issues

Trust in an insurance scheme might relate to the assurance that the clients will receive the benefits due them in the event of illness, and lack of trust discourages enrolment as identified by De Allegri et al. (2006b). In contrast, trust in this study though significant related more to registration agents and less to the assurance of receiving treatment when ill. Ahiatroga's case confirms the influence of lack of trust in the study. He and several others had made an instalment payment to an agent who made away with their money. Since then, it had been difficult for him to raise that amount for premium. He expressed that he was unwilling to register with any other agent again. Meanwhile, since it was costly to make a return trip from his town to the insurance office, he was hoping to register with the officers if there was a mass registration in his town, and if he had saved enough money to pay premium.

Inquiring further, I found that the group which went through this ordeal had informed the insurance officers but nothing had been done about the issue. They had to handle the case on their own. Intuitively, many others who had gone through this experience were unlikely to register with agents. If the scheme officials wanted to restore trust of the population in the scheme and its officials, then it was imperative that the office took the initiative of making the agents accountable and responsible.

Non-economic factors

Political influence

In the discussion of the factors which can influence enrolment, the literatures reviewed, and the theories of decision-making are silent on the play of politics. Surprisingly, there were cases which revealed how political propagandas had had an extent of influence on non-enrolment in this study. Kujovi attributed the deficiencies of the scheme to the ruling party, the National

Democratic Congress (NDC). He expressed that the quality of the services which the scheme used to offer had become poorer since the ruling party was not managing the affairs of the NHIS well.

"You know the NPP introduced this insurance. When they (NPP) were in power everything was going on smoothly. This government (NDC) came to power and has spoiled the scheme. Health workers go on strike every now and then, and the insurance users have to pay for health care", he said.

The ruling party promised in its 2008 election propaganda that it was going to introduce a one-time premium. With this, members will be required to make premium payment once in a life time. However, more than eight years after assuming office the government had not been able to implement this policy due to financial constraints. It is important to point out that some Ghanaians were still hopeful that the policy would be passed. Serwaa was one of such people. She revealed that she was still waiting on the government to introduce this policy. For her it will be a great financial relief. This links positively with her previous statement that she will enrol if someone was willing to pay for her. Others who faced the difficulty to pay were likely to be in her situation.

Chieftaincy disputes

This factor had been ruled out prior to the research. Interestingly, the research revealed its significance at Pitiko. It was illuminating to find out how chieftaincy disputes had influenced non-enrolment. This town had a long standing chieftaincy disputes. As pointed out already, this small town was under the control of three chiefs, each belonging to one of the three ethnic groups. Inquiring from Kuma who hailed from this town, the members of one of these groups had been advised by their chief to decline registration with any agent who belonged to a different group other than their own since they could not be trusted. It is important to emphasize that this town had only one agent, implying that supposing these three ethnic groups had proportional population sizes then at least a third of the population might not enrol. Besides, this town is not easily accessible and a return trip from the insurance office to this town exceeded twice the premium cost, making registration at the office economically unwise.

The OSHIS also revealed that several efforts to embark on mass registration in the town had been halted due to the persistent conflicts. Whenever they decided to organise mass registration exercise, they needed to seek the approval of the chief of the town concerned. The chief then

helped to arrange for a venue and also sensitised the people about the exercise. Meanwhile, this routine was difficult to follow due to the factions which had been created by the disputes. This finding confirms that of Osei-Akoto and Adamba (2009) that ethnic diversity can reduce trust.

Geographical barrier

Again, Kuma pointed out that he had not enrolled due to the high cost of transportation to the health care centre. This cost could be measured in terms of money and time. The town had no health centre and on the average, a return trip to the nearest health centre lasted two hours and exceeded the premium cost. It is significant to point out that the road linking Pitiko to the district capital was not tarred, dirty and quite dangerous to ply on due to its winding nature. Usage became more difficult during the rainy season. This discouraged Kuma from enrolling. This finding agrees with a study by Sarpong et al. (2010) in which distance is a disincentive to enrolment.

On the contrary, Allgri et al. (2006a) points out how this barrier had an insignificant effect in his study due to the competitive range of services which were offered by the lower order health care centres. This implies that government intervention such as providing health care centres which match those at higher order centres, improving the means of transportation and subsidising the cost could be necessary to encourage residents of remote communities to enrol. Similarly, reducing the inequalities in health accessibility through premium exemption might not encourage enrolment so far as rural-urban inequalities in infrastructure provision remain. Meanwhile, the reported rudeness of a health worker, coupled with the difficulties in transportation suggests that Pitiko, like the study sites along the Volta River is not in that competitive position. The study sites lacked those motivators to counterbalance the problem posed by distance and the inequalities in the provision of health care infrastructure.

What challenges the efforts to increasing coverage?

Having elaborated the reasons for non-enrolment from the uninsured's perspective, I turn to a discussion of those challenges identified as crippling the scheme, thereby limiting coverage extension.

Delays in reimbursement

The policy of the NHIS required that claims received from service providers were processed within three months. At the time of the study there was a backlog of claims yet to be processed, according to Nti. In doing this work, a lot of bureaucratic procedures had to be followed. It was necessary that the processing officers ensured that there was no diagnosis mismatch. When the claim was found to be satisfactory, it was then forwarded to the regional NHIA for approval before payment was made. Although this exercise is important to cut down on the cost of fraudulent claims, it often delayed reimbursement which affected financial stability and quality in service provision. It is important to note that this problem had repercussions on health workers' morale and the quality of service provision as indicated by Asante:

"Once we do not receive reimbursement on time, we are not able to pay our workers and restock our supply of medication. In acute situations, we prescribe medicine for all patients to buy", he said.

Meanwhile, some service providers found it difficult to provide accurate accounts which matched their diagnosis and treatment due to the lack of skills about how to fill the new prescription form. This often resulted in the rejection of their claims and a delay in reimbursement. It should be emphasized that adhering to the drug list does not guarantee clients the highest quality of health care. Medical practitioners are better in prescribing medication than the insurers who give the drug list, yet they have little influence over the decisions on the drug prescription list. More efficient means of deciding on a prescription form, evaluating claims and payment should involve the service providers. The quality of service rendered to the insured can be improved through this way.

Inadequate health care facilities

Accessibility to health care had not only been hampered by financial constraints but also by the inequity in the supply of health care infrastructure. Some of the communities within the district had no health centres thereby discouraging enrolment. There was only one hospital which offered referral services within the district, the Atibie Government Hospital. It should be noted that this hospital was further from the study communities and most of the communities within the district were widely scattered. Three of the study communities had health centres which offered primary health care, but they were inadequately staffed and poorly equipped with

facilities. While the provision of health centres in these communities is necessary to encourage enrolment, it is equally important that they are well-equipped to improve the quality of the services they offer.

Inadequate logistics

This problem did not only impede service provision but also registration and claims processing. The insurance office had only one functional Toyota Hilux pickup for all its major and minor operations. This presented transportation difficulties and hampered the ability to conduct registration exercises on frequent basis. Besides, there was inadequate space for operation. The rooms allocated for the scheme's operation were inadequate and often congested, thereby decreasing productivity. Inadequate staffing presented another challenge. Whenever a mass registration exercise was carried out, the scheme had to close its office because the same registration team was used. Moreover, most of the registration staff members were national service personnel on temporal employment. After a year their contract expired and they left their services if the scheme could not employ them. This meant that the scheme lost some of its trained personnel and incurred the additional cost of retraining new staff every year.

Another challenge was with the internet system for registration. It was often slow and made data entry laborious. The problem was acute in the afternoons when clients turned in often. Furthermore, the computer department of the NHIA had no available reporting tools to coordinate and help track the data from the data clerks and other officers. The data system was such that the scheme could not retrieve data sent to the NHIA. This problem impeded in the study by hindering the ability to retrieve statistical information on enrolment recorded by the scheme over the years.

Lack of agents' motivation

While agents were inadequate, Safo voiced that some of the few agents had been discouraged and slowed their enthusiasm to register and renew old members. This was partly due to the reduction of their commission and an introduction of a 10% tax charge on their earnings at the time of the study. This had made their work non-attractive as their net income reduced

drastically. In order to make up for the drop in earnings and sustain a reasonable income threshold, some agents diversified in other activities such as teaching and trading. The declining incentive to work added more duties to the work of the few overburdened staff of the scheme as there were a preference of clients to register at the office. To deal with this challenge, it is important that the NHIA liaise with the Commissioner of Ghana Revenue Authority to consider a waiver of the tax on agents' commission since their services were considered as community voluntary work. More so, the commissions they received should be improved to encourage commitment and dedication.

Chapter summary

In this chapter, I have examined the reasons for non-enrolment, given a characterisation of the uninsured groups, and brought out the limitations to extending coverage in the study contexts. Those excluded from the premium exemption policy, the dependents with dependents, low income earners, the *gyidi kokoo* religious sect, and the *healthy groups* were identified not to be enrolling.

The reasons for non-enrolment have relative importance, suggesting that some are more influential than others. The inability to pay premium is found to have the highest impact on non-enrolment. This reason is significantly related to low and unstable incomes, the difficulty in accessing credit, unemployment and high dependency.

Next, the study reveals an insufficient aversion for risk which is found to be important in the decision of individuals to enrol. This reason is weighty since it influences health-seeking behaviour and quality perception. The expected gain among low risk individuals is low, and it is even worsened further by the multiple health-seeking behaviours they adopt. Since individuals with high health needs received health care from referral centres, it is the so called *healthy groups* who had to content with lower order health centres who were unsatisfied with the quality of health care received. The access to information and trust issues were less influential but the lack of a progressive communication between the scheme officials, service providers and the intended clients for extending coverage is found to limit enrolment. It can be emphasised that access to information might not always be a problem but the absence of an effective communication between insurers, health service providers and their intended population.

Overall, the socio-economic factors are more important. The non-economic factors, namely the influence of politics, geographic barriers and chieftaincy disputes although significant, can be termed as less influential. The reason is that they are unrelated to the situations of the uninsured themselves. Besides, the cases which reveal these reasons as significant are exceptional and confined to a particular group within the study.

The challenges to extending coverage are found adding impetus to reducing the attractiveness of the scheme to the uninsured. Since they are related to the scheme and service provision, improvement can be a useful solution to increasing enrolment.

Conclusion

In this thesis, I have examined the issues relating to non-enrolment into Ghana's National Health Insurance Scheme laying emphasis on the Okwahuman South Health Insurance Scheme.

I have addressed significant related issues. These encompassed what enrolment procedures existed, how they influenced enrolment, what characterised the uninsured groups, what reasons they gave for their status, and what challenged the extension of coverage.

The research finding reveals that the enrolment procedures have a significant influence on non-enrolment in the scheme. Inconvenience in registration is one limitation found which can be related to wrong timing of mass registrations, and the cost of transportation. The study reveals how potential enrolees miss registering due to inconvenience in the timing of mass registration and, others because of cost. For instance, those who live in villages further away from the registration office but linked poorly by road networks are among those who are discouraged to enrol. Besides, the lack of trust in the insurance agents owing to previous bad experiences with these agents is found to adding weight to, but not assisting in easing the problem of the inconvenience in registration.

Another finding of this work which agrees with the study by Jehu-Appiah et al. (2011a) is that the indigent policy is missing out on a significant number of indigents due to the age categorisation barrier, discriminatory selection procedure, difficult registration requirements and the lack of a conscious effort to sensitize people about the policy to attract large numbers of indigents. Financial constraints are found to be the underlying reason for the lack of a desire to extend coverage through indigent enrolment. Since there is a quest to achieve a universal coverage status, it is imperative that the government weighs the agenda to make the district insurance schemes financially independent against the benefits of continually increasing its monetary support to the schemes. Sacrifices may have to be made.

It is evident that in the efforts to cover the entire population, socio-economic factors represent the greatest challenge as my field work has shown. Although the factors have different weights, financial barrier is the strongest. The study agrees with that of De Bock and Gelade (2012) and it is consistent with other findings too.

Another finding is that the need to maximise gains is important in the decision to enrol. The fieldwork revealed how those who perceived fewer gains were unlikely to enrol. Those who often perceived fewer gains included the *healthy*, and *independent without dependents*. My

research findings have shown how those who perceive to have good health do not enrol due to their fewer expected prospects. This shows that the principle that the healthy and the rich subsidize the health care cost for the poor and ill, an inherent concept which has been an argument for promoting SHI as a tool for achieving universal health coverage is not always realistic or easily achievable.

There are also problems posed by religious beliefs which reduce the aversion for risk, and multiple health-seeking behaviours. The study has revealed that a disbelief in the scientific explanations to disease causation represents a disincentive to enrolment. Additionally, the presence and preference for much affordable health-seeking alternatives such as the practice of self-medication, and the use of traditional herbal medicine also reduce the aversion for risk, thereby hindering enrolment. In prioritizing the decision to use health insurance, considering cheaper alternatives to health care is important among the groups with the limited ability to pay due to the need to cut down on the cost of health care. All the aforementioned findings were expected as the literatures revealed them.

Below I present those surprising findings which deviate from the expected. First, informal workers with low and unstable incomes were not enrolling. Even though they were expected to be more risk-averse, and consider the decision to enrol against the need to satisfy more pressing basic needs with the limited financial resources at their disposal, they acted contrary. In other words, consumption was placed above the need to insure.

Furthermore, dependency is found to increase financial constraints and limit enrolment. A person with many dependents is unlikely to enrol due to the pressure to register dependents. A married man for instance is not only responsible for enrolling his children but also his wife, and in some cases the non-working members who do not have the means to pay. The problem is even more profound among credit constrained individuals and dependents with many dependents. This shows that higher dependency does not always encourage enrolment because of the aversion for risk, a finding which contradicts that of LeMay-Boucher (2007).

Contrary to the study by Jowett (2003) this study showed that solidarity does not always lead to a mutual benefit or reinforces cohesion which encourages enrolment. The traditional support network is growing weaker as confirmed by Aboderin (2004). This study showed how difficult it could be to obtain financial support from relatives, although the belief of putting the health concerns of the most vulnerable members of the nuclear family first still exists. This means that the belief that the weaker members of the family should be taken care of is not being

reciprocated by financial support among members. Another surprising finding is that the absence of competitive schemes and risk-sharing groups had not encouraged enrolment as argued in the consumer and status quo bias theories.

While the socio-economic factors influenced the decision to enrol most, there were non-economic factors which reveal an area for further research. The play of politics can be detrimental to enrolment, although political structures carry the potential to roll out policies which can achieve universal health coverage. An obvious one is the mention of an introduction of a one-time premium which was later found to be unrealistic. It carries a promise of offering financial relief, and this is still an assurance of aid to those who cannot buy insurance, keeping them in a state of hope but slowing down individual initiatives to insure them. It is important that traditional political situations are also examined when aiming to extend insurance coverage, especially in rural areas and small towns where disputes create factions among groups which are already heterogeneous. Instead of neglecting such issues or regarding them as unrelated to the implementation of national policies, it is better that they are addressed as they can impede success as found in this study.

The uninsured's state is not only a matter of individual situations. The challenges of a scheme itself may influence enrolment. This study revealed cases which hinder efforts aimed at increasing enrolment. One factor is the delays in reimbursement of service providers. This problem is found to affect the quality of service and the value obtained from the benefit package of the insurance scheme. Another finding was the lack of agents' motivation which affected their commitment to job because of the need for them to diversify into other income generating activities. Furthermore, there is inadequate supply of logistics and staffing to ensure effectiveness of work. Since a goal of an insurance scheme is to improve accessibility to health care, inequalities in the provision of health care infrastructure should be tackled, if equity can be achieved through health insurance. This suggests that focusing on improving individual or household socio-economic conditions is only one of the numerous pathways to tackling the problem of low enrolment.

Reiterating the contribution of Ghana's NHIS as a social protection policy which is helping to eliminate financial barriers to health care accessibility by incorporating the low income earners and the poor, it is important to point out that it is still falling short of its objective. The results of the research reveal that insurance financed through member contributions is not always the easiest or perfect model for extending coverage. Financing through general taxes might carry

that desired potential as made explicit by Mathuer et al. (2008). Reviewing the revenue sources of Ghana's scheme, its benefits can even be limited when a flat rate premium is charged, as it puts those low income earners at a more disadvantaged position, since they spend the little they have too on consumer goods which are taxed for income generation towards scheme financing.

Although the small size of the formal working sector presents a challenge to increasing revenue generation through general taxes, relying on contributions from informal workers does not offer a solution either. The risks pools from this kind of financing will be inadequate and selective; bearing in mind that the expected gains from enrolment is higher among low income groups. Besides, the principle of mandatory participation inherent in a contributory scheme cannot be enforced due to the barrier of the inability to pay, unless enough subsidies reach the poor and low income groups classified on the basis of their nature of job if the size of income cannot be estimated. If schemes by principle are non-profit-seeking, then it is imperative that governments show commitment by providing financing support. It is evident that where such support is not forthcoming, management will lose the enthusiasm for encouraging enrolment through indigent registration because it will mean compromising on revenue mobilisation from members.

Finally, it is indisputable that health insurance is an important tool for providing security against catastrophic health care expenditure as outlined in the genesis of this thesis. It creates a sort of financial safety net for members, thereby offering social protection. The concern however has been how to ensure that those most vulnerable to the risk of high health cost benefit from this protection through coverage. Income and age are only two of the numerous ways by which indigents can be identified. Where these prove insufficient variables, household size and the number of working members present, the health status of members, geographical targeting, wealth ranking, and occupational categorisation may be useful. More importantly, eliminating direct payments, making scheme participation compulsory, increasing government support to cover the health cost of those who cannot afford to pay, and the creation of large risk pools are necessary ingredients to increasing coverage.

My study has revealed that a SHI scheme itself is not the ultimate tool for achieving universal health coverage, but rather that the inherent policies, and the implementation procedures of any model of health insurance is of utmost importance. I do not recommend a straight pathway, but that the suitability of each model for every socio-economic condition should be examined.

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Appendices

Appendix 1: Socio-economic background of informants

Informants Anonimous	Age	occupation	Gender	Level of Education	Religion	Married with children	single	Married without Children	Tribe
Ofori	48	Insurance agent	Male	Basic	Christian	Yes			Ewe
Vida	34	Hairdresse r	Female	Basic	Christian	Yes			Kwahu
Serwaa	33	Unemploy ed	Female	Basic	Christian	Yes			Kwahu
Rose	31	Trader	Female	Basic	Christian	Yes			Kwahu
Asibi	30	Fishmong er	Female	Basic	Islam	Yes			Ada
Kwaku	23	Apprentic e	Male	Basic	Christian		Yes		Kwahu
Sika	47	Fisherman	Male	Basic	Christian	Yes			Ewe
Ago	28	Trader	Male	Basic	Christian		Yes		Ewe
Selasi	25	Unemploy ed	Female	Basic	Christian	Yes			Ewe
Dela	36	Farmer	Female	Basic	Christian	Yes			Ewe
Ahiatroga	28	Fisherman	Male	Basic	Christian	Yes			Ewe
Bright	14	Student	Male	Basic	Christian		Yes		Kwahu
Nyarko	67	Retired	Female	Basic	Christian			Yes	Kwahu
Boja	53	Trader	Male	Secondary	Islam	Yes			Ada
Kuma	75	Retired	Male	Basic	Christian			Yes	Kwahu
Kojovi	36	Fisherman	Male	Basic	Christian			Yes	Ewe
Adelakope	28	Farmer	Male	Basic	Christian	Yes			Ewe

Bempa	32	Farmer	Male	Basic	Christian	Yes			Kwahu
Asante	61	official	Male	Tertiary	Christian	Yes			Kwahu
Poku	62	Unemploy ed	Male	Basic	Christian			Yes	Kwahu
Safo	48	official	Male	Tertiary	Christian	Yes			Kwahu
Nti	38	official	Male	Tertiary	Christian	Yes			Kwahu
Coby	12	Student	Male	Basic	Christian		Yes		Kwahu

❖ Asante, Safo and Nti were insured officials, the rest were uninsured informants

Source: Fieldwork 2013

Appendix 11: Interview guide

Introduction of the research

Informed consent, asking permission for recording

Giving my contacts to informants

General questions

Age, gender, ethnic background, religion

Marital status: with or without dependents

Occupation

Level of education

To the uninsured

What do you know about the NHIS?

(Premium rate, the indigent policy, registration and renewal)

Why are you uninsured?

Would you prefer to insure?

Can you afford to enrol?

What is your preferred point of registration?

When can you afford premium payment?

Which modality of premium payment do you prefer example: one-time payment or instalments?

How do you perceive the national health insurance scheme?

The previously insured

Why have you not renewed your membership?

When did you leave the scheme?

Would you like to re-enrol?

Do you know about the indigent policy?

What experiences have you had with using the national health insurance

Risk perception and health-seeking behaviour

How would you describe your health status?

Have you experienced any health shock lately?

When do you seek health care from the hospital?

Do you seek health care anywhere aside the hospital?

Do you have any knowledge of alternative health insurance?

Explain your beliefs concerning disease causation and health insurance

Support for handling health risk

How do you finance your health care cost: drawing on savings, from relatives?

Are you a member of any solidarity group?

Do you join any insurance scheme?

Accessibility to formal health care

How much (money) do you spend to get to the nearest health centre?

How much time will it take: at the health centre, embarking on a return trip?

Have you observed any difference in the procedure for obtaining health care for you and others?

Is there something else that is important you would like to add?

The health officer

Are there any similar characteristics for those who are uninsured which makes them different from the insured?

Is there anything about (age range, gender, marital status, employment, educational level?)

Is there an illness which is not covered under the NHIS which is important in your context?

What is the general situation on health insurance usage?

Are there groups who are seeking care without insurance? If yes who are they?

What changes in enrolment have you observed over time?

Are there differential procedures for obtaining health care for the uninsured and insured?

What are your views on affordability of health insurance to the uninsured patients?

Are the uninsured incurring lower health cost than the insured or otherwise?

Is there a feature in the scheme that makes people stay out of it? Example, is it favouring the rich or poor?

Do you encounter any difficulties in providing services for the insured and uninsured?

What suggestions do you have for addressing these difficulties?

The district mutual health insurance

How does the national health insurance work: (registration procedures and points), renewals, marketing strategies, premiums, and mechanisms for checking adverse selection, benefit package)?

Are there some identifiable groups who are not taking insurance?

Who are they and why do you think it is so?

Are there any features of the scheme which limit enrolment?

What difficulties do you encounter in getting people to enrol? 7

What changes have you witnessed in enrolment rates among the following?

(Males, females, children, adults, elderly, formal and informal workers, married, single, those with dependents and without,

Indigent selection

What measures exist for raising awareness about?

(The policy, selection, eligibility, registration)

How is indigent targeting done?

Do people self-report as indigents? How often

What difficulties are encountered in implementation of the scheme?

(Generally and in your context: registration, management, funding)

(Health care provision and accessibility, claims payment,)